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The Obesity Epidemic:

SAN DIEGO'S PLAN TO ADDRESS CHILDHOOD OBESITY

By Adrienne Yancey, MPH, and Wilma J. Wooten, MD, MPH

As more Americans than ever before are overweight, it is appropriate to bring attention to this issue during a time of year when so many fad diets are started and abandoned. The United States is experiencing considerable increases in overweight (defined for adults as a body mass index (BMI) greater than 25) and obesity (BMI greater than or equal to 30).

The U.S. Surgeon General's *Call to Action to Prevent and Decrease Overweight and Obesity*, released in 2001, reports that approximately 300,000 adult deaths in the United States each year can be attributed to unhealthy dietary habits and physical inactivity or sedentary behavior (1, 2). According to data from the 1999-2000 National Health and Nutrition Examination Survey (NHANES), nearly two-thirds of adults in the United States are overweight, including 27 percent of those who are obese (3).

These statistics are staggering, but the problem does not stop with adults. Increased weight gain now cuts across all ages, racial and ethnic groups, and both genders (4). Nationally, the prevalence of obesity has doubled in children (from 7 to 13 percent), and tripled in adolescents (from 5 to 14 percent) over the past two decades (5). San Diego County's children are following the same trend with as many as 36 percent being overweight (6). Most disconcerting is that 70 percent of overweight adolescents become overweight adults. Due to the overwhelming increase in childhood obesity, the third week of January is now designated as Healthy Weight Week.

Overweight and obesity are caused by many factors, including a combination of genetic, metabolic, behavioral, environmental, cultural, and socioeconomic influences. Numerous environmental factors have also contributed to the increase in childhood obesity, including urban sprawl, availability of junk food, growing portion sizes, lack of safe play areas, and the increasing popularity of television, video games, and computer use. These problems are so huge that they seem insurmountable. By in large, the greatest contributors to overweight and obesity are behavioral and environmental factors, which also provide the best opportunity for actions and interventions designed for prevention and treatment. Additionally, there are many strate-

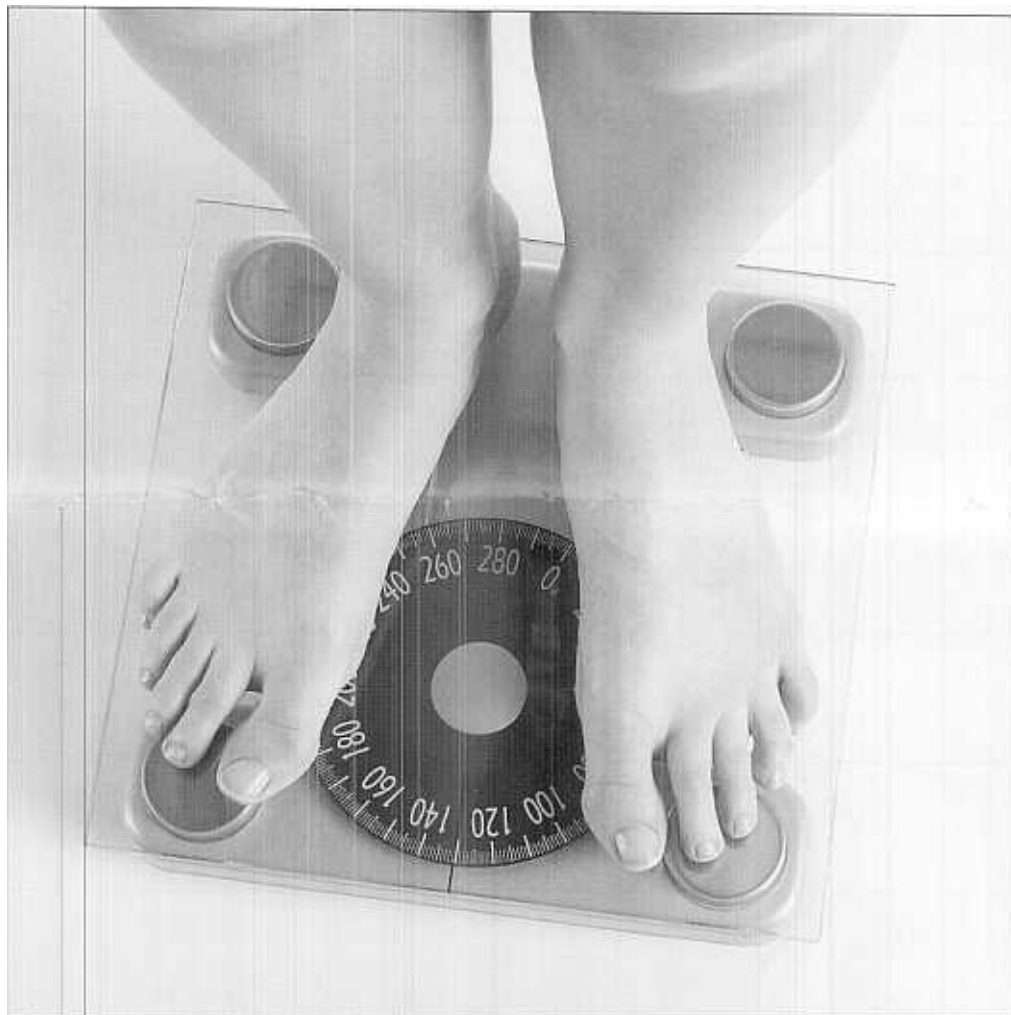
gies that a health professional can implement in the clinical setting to help curb this epidemic.

Growing research points to a child's early food experiences as a critical time for preventing childhood obesity and creating lifelong healthful eating habits. Healthcare providers have a great opportunity to prevent childhood obesity by teaching parents the basic feeding dynamics principals introduced by renowned child nutrition expert Ellyn Satter. These principals explain that children have an innate ability to recognize hunger and satiety cues. When parents interfere with this by forcing children to eat when they are not hungry or restricting food when they are hungry then children lose their natural hunger and satiety cues resulting in overeating. The division of responsibility was developed to communicate the feeding / eating responsibilities of the parent and the child. Parents are responsible for what food is served and when it is served; children are responsible for how much or even whether to eat. By practicing this division of responsibility consistently, along with offering healthful food choices and many opportu-

nities for physical activity, a child will have a much better chance of reaching and maintaining a healthy weight (7).

Another equally important role of the physician is to chart a child's growth utilizing the Centers for Disease Control and Prevention (CDC) BMI-for-age growth charts (8). It is important to note that when charting a child's growth, not only is the child's growth compared to the chart standards, but also this practice presents an opportunity to review the child's growth acceleration looking specifically for any abnormal upward weight divergence for that individual child. This is valuable for two reasons because it: 1) prevents inappropriately labeling a child with a higher set weight as overweight and 2) allows for early detection and intervention to prevent further divergence from that child's normal growth pattern.

San Diego County is aggressively addressing the overweight and obesity epidemic through the development of a comprehensive countywide Childhood Obesity Action Plan to coordinate current efforts and serve as a roadmap for change. In



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October 2004, at the recommendation of Chairwoman Pam Slater-Price and Supervisor Ron Roberts, the San Diego County Board of Supervisors unanimously voted "to support the creation, coordination, and implementation of a Childhood Obesity Master Plan to end childhood obesity." Community Health Improvement Partners (CHIP) — a collaboration of organizations with the common goal of achieving improved health for San Diego communities — assisted in the coordination of the plan. Individuals with special expertise in the areas of healthcare, nutrition, and physical activity were invited to serve on a steering committee to guide the process. With input from multidisciplinary partners, community residents, and others, the steering committee developed the *Call to Action: San Diego County Childhood Obesity Action Plan*. The objectives of the plan include:

- Building awareness about the problem of childhood obesity;
- Serving as a guide for all those interested in San Diego County in addressing childhood obesity, including agencies, institutions, and neighborhoods;
- Planting a seed and building momentum for action without being prescriptive;
- Catalyzing partnerships for those already working on this issue with new organizations and new sectors;
- Ensuring strategies emphasize policy and environmental changes and not just individual and family efforts; and
- Creating a plan document that supports community partners in their efforts.

The plan is structured around the ecological model of health promotion, which focuses on environmental changes, behaviors, and policies that help individuals make health choices in their daily lives. Strategies for the plan are presented in seven domain areas: city and county governments; healthcare systems and providers; schools; child-care, preschools and before- and after-school providers; community-based, faith-based, and youth organizations; media outlets and marketing industry; and businesses. Scheduled for release in late January 2006, the plan will encourage organizations to join others in the county and make their own formal commitment to adopt and implement a strategy from the plan.

If there is an interest in making a commitment to address childhood obesity or if more information about the obesity plan is needed, contact (619) 692-5693. For more information on local obesity prevention efforts, trainings, or resources, please visit the Coalition on Children and Weight San Diego website at www.ccwsd.net. The Coalition is currently collaborating with the American Academy of Pediatrics on school advocacy to improve the school nutrition and physical activity environment. ❧

References: ■ 1) McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA* 1993 Nov 10;270(18):2207-12. ■ 2) Allison DB, Fontaine KR, Manson JE, Stevens J, VanItallie TB. Annual deaths attributable to obesity in the United States. *JAMA* 1999 Oct 27;282(16):1530-8. ■ 3) NCHS, CDC. Prevalence of overweight and obesity among adults: United States, 1999 [Internet]. [Hyattsville (MD)]: NCHS [cited 2001 Oct 31]. Available from: www.cdc.gov/nchs/products/pubs/pubd/hestats/obese/obse99.htm. ■ 4) Eberhardt MS, Ingram DD, Makuc DM, et al. Urban and rural health chartbook. Health, United States, 2001. Hyattsville (MD): NCHS; 2001. p. 256. ■ 5) NCHS, CDC. Prevalence of overweight among children and adolescents: United States, 1999 [Internet]. [Hyattsville (MD)]: NCHS [cited 2001 Oct 31]. Available from: www.cdc.gov/nchs/products/pubs/pubd/hestats/over99fig1.htm. ■ 6) California Center for Public Health Advocacy. An Epidemic: Overweight and Unfit Children in California Assembly Districts. 2002. ■ 7) Satter E. Position Statement: Eating Management to Prevent and Treat Child Overweight. 2004. www.ellynsatter.com. ■ 8) National Center for Health Statistics (NCHS), CDC. CDC Growth Charts: United States [Internet]. [Hyattsville (MD)]: NCHS [cited 2001 Oct 31]. Available from: www.cdc.gov/growthcharts.

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SAN DIEGO COUNTY HEALTH STATS

Childhood Obesity

- In San Diego County, 13.9% of adolescents, ages 12–17, are overweight or obese. This includes adolescents who have a body mass index (BMI) in the 95th percentile with respect to their age and gender (1).
- In San Diego County, 54.0% of adults, ages 18 and up, are overweight or obese, with a BMI of 25 or greater (1).

January 15–21, 2006, is Healthy Weight Week. For more information about Healthy Weight Week, visit www.healthyweight.net. To request additional health statistics describing health behaviors, diseases and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 285-6479. To access the latest data and data links, including the 2004 Core Public Health Indicator document, visit www.sdhealthstatistics.com.

References: ■ 1. California Health Interview Survey, 2003, Los Angeles, CA: UCLA Center for Health Policy Research.

Heart Health Month:

INCREASING AWARENESS ABOUT CARDIOVASCULAR DISEASE

By Wilma Wooten, MD, MPH

February is "Heart Health Month," which is designated to help educate the public about heart disease and how to stay healthy. It is also an excellent opportunity to remind providers about the use of prevention efforts to help reduce morbidity and mortality associated with heart disease and related risk factors.

More than 70 million Americans, one-fourth of the population, live with a cardiovascular disease. Over 6 million hospitalizations each year are due to cardiovascular disease (CVD).

Heart disease and stroke, the principal components of cardiovascular disease, are the first and third leading causes of death for both men and women in the United States, accounting for nearly 40 percent of all deaths. Over 930,000 Americans die of cardiovascular disease each year, which amounts to 1 death every 34 seconds. Although these largely preventable conditions are more common among people aged 65 years or older, the number of sudden deaths from heart disease among people aged 15–34 has increased in recent years (1). Coronary heart disease (CHD) is the leading cause of death for American women. One in five women has some form of heart or blood vessel disease. Additionally, one in three American women dies of heart disease (2). In 2001, 931,100 people died from heart attacks and other coronary events; 498,900 (53.6 percent) of those victims were women (3).

The economic impact of cardiovascular disease on the U.S. healthcare system continues to grow as the population ages. Nationally, the rate of death due to coronary heart disease was 170.9 in 2002. Over 8 million Americans are disabled due to cardiovascular disease. Coronary heart disease is a leading cause of premature, permanent disability in the U.S. workforce. Stroke alone accounts for disability among more than 1 million Americans. The cost of heart disease and stroke in the United States is projected to be \$394 billion in 2005, including healthcare expenditures and lost productivity from death and disability (4).

In recent years in San Diego County, the rate of death due to coronary heart disease decreased by almost 25 percent from 203.3 per 100,000 population in 1995 to 155.2 in 2003. Deaths due to coronary heart disease disproportionately impact blacks / African Americans with a rate of 217.5 per 100,000 compared to whites (161.3/100,000),

Heart disease and stroke, the principal components of cardiovascular disease, are the first and third leading causes of death for both men and women in the United States, accounting for nearly 40 percent of all deaths.

Hispanics (138.1/100,000), and Asians / others (99.8/100,000). The rate of death due to coronary heart disease is 40 percent lower in women (120.7/100,000) compared to men (199.1/100,000) (5).

Locally, the rate of hospitalizations due to coronary heart disease decreased by 13 percent from 513.6 per 100,000 population in 1997 to 445.1 in 2003. The number of hospitalizations related to coronary heart disease among San Diego County residents decreased slightly from 13,627 in 1997 to 13,254 in 2003. For ages 65 and up, the number of hospitalizations decreased 8 percent from 8,918 in 1997 to 8,219 in 2003. However, in the age group of 55–64 there was an increase in hospitalizations from 2,402 in 1997 to 2,845 in 2003 (6).

Physicians positively impact these trends by assessing their patients for cardiovascular risks and advising them on healthier lifestyle choices. The American Heart Association has identified several risk factors that patients can modify, treat or control by changing lifestyle or taking medicine.

Tobacco Smoke: Smokers' risk of developing coro-

nary heart disease is 2–4 times that of nonsmokers. Cigarette smoking is a powerful independent risk factor for sudden cardiac death in patients with coronary heart disease; smokers have about twice the risk of non-smokers. Cigarette smoking also acts with other risk factors to greatly increase the risk for coronary heart disease. People who smoke cigars or pipes seem to have a higher risk of death from coronary heart disease (and possibly stroke), but their risk is not as great as that of cigarette smokers. Exposure to second-hand smoke increases the risk of heart disease even for non-smokers.

High Blood Cholesterol: As blood cholesterol rises, so does risk of coronary heart disease. When other risk factors (such as high blood pressure and tobacco smoke) are present, this risk increases even more. A person's cholesterol level is also affected by age, sex, heredity, and diet.

High Blood Pressure: High blood pressure increases the heart's workload, causing the heart to thicken and become stiffer. It also increases your risk of stroke, heart attack, kidney failure and heart failure. When high blood pressure exists with obesity, smoking, high blood cholesterol levels or diabetes, the risk of heart attack or stroke increases several times.

Physical Inactivity: An inactive lifestyle is a risk factor for coronary heart disease. Regular, moderate-to-vigorous physical activity confers the best benefits. However, even moderate-intensity activities help if done regularly and long term. Exercise can help control blood cholesterol, diabetes and obesity, as well as help lower blood pressure in some people.

Obesity and Overweight: People who have excess

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San Diego County Health Stats: Heart Health

- In San Diego County, 6.6% of adults, ages 18 and up, have been diagnosed with heart disease (1).
- The primary cause of death among San Diego County residents is diseases of the heart, with 16,158 deaths from 2001–2003, which is 27% of all deaths in the County (2).

February is Heart Health Month. For more information about Heart Health Month, go to www.americanheart.org. To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 285-6479. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

References: ■ 1. California Health Interview Survey, 2003, Los Angeles, CA: UCLA Center for Health Policy Research. ■ 2. State of California, Death Statistical Master File-Prepared by Community Epidemiology County of San Diego, Health & Human Services Agency.

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body fat — especially trunkal obesity — are more likely to acquire heart disease and stroke even if they have no other risk factors. Excess weight increases the heart's work. It also raises blood pressure and blood cholesterol and triglyceride levels, and lowers HDL cholesterol levels. It also potentiates the development of diabetes. Many obese and overweight people may have difficulty losing weight, but by losing even as few as 10 pounds, one can lower heart disease risk.

Diabetes Mellitus: Diabetes seriously increases risk of developing cardiovascular disease. Even when glucose levels are under control, diabetes increases the risk of heart disease and stroke, but the risks are even greater if blood sugar is not well-controlled. There are 20.8 million people in the United States, or 7 percent of the population, who have diabetes. Unfortunately one-third, 6.2 million individuals do not know it (7). About three-quarters of people with diabetes die of some form of heart or blood vessel disease.

Healthcare providers perform age-appropriate CVD and CHD assessment utilizing online risk-assessment tools available on the following websites:

- <http://hin.nhlbi.nih.gov/atpin/atp3palm.htm>
- <http://www.nhlbi.nih.gov/guidelines/cholesterol/profnats.htm>

The following key items should be a part of routine assessments and documentation:

- Smoking status
- Body mass index and waist circumference

- Blood pressure
- Complete lipoprotein panel (total cholesterol, low-density lipoprotein cholesterol, high-density lipoprotein cholesterol, and triglyceride levels)
- Fasting blood glucose level (to screen for diabetes)
- Dietary habits
- Physical activity habits
- Family history of heart disease
- Age

For more information and patient educational materials, including in Spanish, contact the American Heart Association at (858) 410-3850 or www.americanheart.org.

References:

1. Preventing Heart Disease and Stroke, Addressing the Nation's Leading Killers. At A Glance 2005. Centers for Disease Control and Prevention.
2. Sandmaier M. Healthy Heart Handbook for Women. Bethesda, Md.: U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2003.
3. Accessed website www.americanheart.org, February 8, 2006.
4. Preventing Heart Disease and Stroke, Addressing the Nation's Leading Killers. At A Glance 2005. Centers for Disease Control and Prevention.
5. State of California Department of Health Services, Death Statistical Master Files; SANDAG Population Estimates, 2003.
6. California Office of Statewide Health Planning & Development (OSHPD) Hospital Discharge Data; SANDAG Population Estimates, 2003.
7. Accessed website <http://diabetes.org/about-diabetes.jsp>, January 24, 2006.

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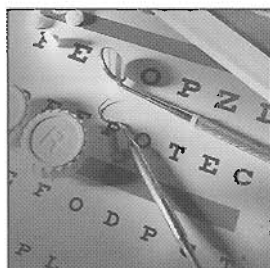
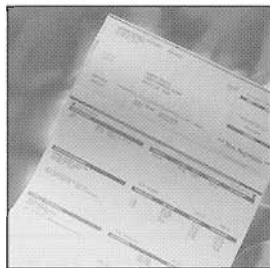
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Avian Influenza (H5N1)

By Michele Ginsberg MD, Elaine Pierce MD, MPH, Nancy Bowen MD, MPH, Louise Gresham PhD, MPH, County of San Diego Health and Human Services Agency, Public Health Services, Community Epidemiology Branch

It's an average week in your busy practice, when, over the space of a few days, three situations come up:

1. You receive a call from Mrs. Lawrence, one of your regular patients, stating that she plans to visit rural Viet Nam for a month-long trip with her church group. She would like to know what her risks are for contracting avian influenza. "I want to shop in the local markets. Doctor. Is that OK if there are live birds there? Can I eat chicken? What about eggs?"
2. Another patient, Steven Jones, returned from Turkey yesterday and is worried about the recent news of human H5N1 disease reported from that area. He complains of two days of a sore throat, mild cough, and fever with chills. "Do I have bird flu, Doc? Should I come in and see you right away?"
3. When you walk into the exam room, you notice immediately that Lucy Tanghkanaurak appears acutely ill. She has a fever of 102.8 degrees, and she is sneezing and coughing. She complains of severe body aches, non-bloody diarrhea and weakness. You note that her respiratory rate is twenty breaths per minute, and on auscultation of the lungs, you hear rales and rhonchi bilaterally. As you take a history, you discover that she returned five days ago from a trip to Thailand, where she stayed with her relatives and assisted in cooking family-raised poultry. At this point, what do you do?

Physicians in San Diego County can expect to field numerous questions from a concerned public about avian influenza (H5N1) as media coverage of this potential health threat increases. Given the large volume of international traffic to this area, we are also at-risk of seeing imported cases of human H5N1 illness. Part 1 of this article covers key information on recognizing the disease and confirming the diagnosis; Part 2 reviews biologic, epidemiologic, and clinical characteristics.

PART 1: CORE CONCEPTS

Current Case Definition

There are two ways to meet the case definition for suspect avian influenza:

1. Hospitalized patients with:
 - ▶ Radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which

an alternate diagnosis has not been established

- ▶ AND travel within 10 days of symptom onset to a country with documented H5N1 avian influenza in birds and/or humans.
 - ▶ Testing for avian influenza A (H5N1) is indicated in these patients.
2. Hospitalized or ambulatory patients with:
 - ▶ Documented fever > 100.4° F (38° C)
 - ▶ AND one or more of the following: cough, sore throat, shortness of breath
 - ▶ AND history of contact with poultry (e.g. visited a poultry farm, a house raising poultry, or a bird market) or a known or suspected human case of influenza A (H5N1) in an H5N1-affected country within 10 days of symptom onset.
 - ▶ Testing for avian influenza A (H5N1) should be considered on a case-by-case basis in consultation with local health departments for these patients.

Virologic Diagnostic Techniques

- ▶ A negative rapid antigen test for influenza never rules out avian influenza (H5N1). The average sensitivity of these tests for seasonal influenza is only about 70 percent, and sensitivity may be lower for novel strains of influenza.
- ▶ Collection of specimens for confirmatory testing requires the use of Viral Transport Medium (VTM).
- ▶ One study found a 10-fold higher concentration of the H5N1 virus in the throat than the nasopharynx; therefore, both nasopharyngeal and oropharyngeal specimens should be collected using Dacron or rayon swabs on plastic sticks. Each swab should be placed in a separate vial of VTM and shipped to the laboratory on ice pack.
- ▶ Whenever avian influenza (H5N1) is suspected, the specimen should be sent to the San Diego Public Health Laboratory, not to commercial labs.
- ▶ Because viral culture poses a risk of infection to laboratory workers, it is imperative that the specimen is labeled "SUSPECT AVIAN INFLUENZA." This alerts the lab personnel to perform the diagnostic test of choice for H5N1, which is RT-PCR.
- ▶ The SD PH Lab will process the specimen with the H5 RT-PCR primer once two things have occurred:
 - ▷ The clinician has discussed the case with Community Epidemiology and there is mutual agreement that the patient fits the case definition.
 - ▷ The "Laboratory Specimen Submission Form for Suspect Avian Influenza (H5N1)" has been completed and accompanies the specimen. This form can be downloaded

from EMAN (see below); alternatively, Community Epidemiology can fax this form to the clinician's office.

The Role of San Diego Public Health Services, Community Epidemiology Branch

- ▶ Avian influenza (H5N1) is a reportable disease. If you feel you may have a suspect case, call the Community Epidemiology Branch immediately, 24 hours a day, 7 days a week:
 - ▷ M–F, 8AM–5PM: (619) 515-6620
 - ▷ After business hours and on weekends: Station M (858) 565-5255
- ▶ Subscribing to the online San Diego Emergency Medical Alert Network (EMAN) will help you stay abreast of the local infectious disease developments, including avian influenza. The case screening, case report and specimen submission forms can be downloaded from the EMAN site.
- ▶ To subscribe to EMAN, go to: www.emansandiego.com.

Case Scenarios Revisited

1. Mrs. Lawrence should be told that as of February 27, 2006, there are no travel restrictions to countries with human H5N1 disease (updated information for travelers may be found at www.cdc.gov/travel/other/avian_influenza_se_asia_2005.htm). During her stay in Viet Nam, care should be taken to avoid contact with live, well-appearing, sick, or dead poultry and with any surfaces that may have been contaminated by poultry or their feces or secretions. Live bird markets should be avoided. Prohibited activities include food preparation that involves raw poultry. Influenza viruses are readily killed at cooking temperatures. While eating thoroughly cooked poultry products has not been associated with disease, she should avoid eating undercooked, bloody-appearing poultry or eggs with runny yolks.
2. The correct advice for Steven Jones depends on whether he was exposed during the right time frame (within ten days of symptom onset) and whether he engaged in any high-risk behavior as listed in the second part of the case definition. Community Epidemiology will review the case specifics with you and make recommendations. If it is decided that this individual is at risk for avian influenza, he should receive further evaluation in a hospital emergency department setting, and the department should be notified ahead of time to expect him. Ideally, he should not sit in a common waiting room but should be given a surgical mask on entry and taken immediately to a private examination area. Had Mr. Jones already been in your office when you obtained his history, then again, a call

and Your Practice

to Community Epidemiology will help you determine whether he meets part two of the case definition. If so, then a rapid antigen test and, more importantly, nasopharyngeal and oropharyngeal specimens should be taken, with the latter sent in viral transport medium (VTM) on ice pack to the Public Health lab. Clinic staff should use personal protective equipment (PPE) when caring for Mr. Jones.

3. Ms. Tanghkanaurak is likely to fit part one of the case definition for avian influenza (H5N1): her pneumonia has not been radiographically confirmed but you have a strong suspicion clinically. Clinic staff should use PPE, and a surgical mask should be placed on the patient if she can tolerate it. Family members and/or paramedics who will transport her to a hospital emergency department should also wear PPE, and the hospital should be advised ahead of time that a patient with suspected H5N1 disease is on the way. Community Epidemiology should be notified immediately.

Contact with the Community Epidemiology Branch of San Diego County Public Health Services should be the clinician's first step when avian influenza (H5N1) is suspected.

PART 2: REVIEW OF THE DISEASE

Infectious Agent

- ▶ An orthomyxovirus that contains a single-stranded segmented RNA genome prone to replication errors leading to a high rate of mutation.
- ▶ Subgroup identification is based on the properties of surface glycoproteins: hemagglutinin (H) and neuraminidase (N).
- ▶ H1 and H3 are the current circulating seasonal (human) influenza subtypes. Since 1997, highly pathogenic avian influenza (H5N1) has caused sporadic illness in man with high mortality rates.

Reservoir

- ▶ Migratory aquatic waterfowl are generally asymptomatic carriers of various avian influenza strains, but recently there have been a number of large wild bird die offs due to H5N1, an unusual phenomenon.
- ▶ Domestic poultry may become infected after co-mingling with wild birds or swimming in the same bodies of water; H5N1 may be highly pathogenic to these birds, causing rapid mortality.

The distribution of the disease in birds and humans is rapidly evolving. The following sections are based on information available as of February 2006.

Geographic Distribution

- ▶ No human or avian cases of H5N1 are currently known to exist in North America.
- ▶ Since 2004, gradual east-to-west spread of the virus from its origins in Southeast Asia has followed the migration paths of wild birds. Countries in the Middle East, the Indian subcontinent, Europe, and Africa have reported infected bird populations.
- ▶ As of February 27, 2006, the World Health Organization reported 171 laboratory-confirmed cases of human H5N1 disease and 93 deaths worldwide. The countries involved are Cambodia, China, Indonesia, Iraq, Thailand, Turkey, and Viet Nam. Viet Nam has been the hardest hit, with 93 human cases and 42 deaths.
- ▶ The Asian migratory bird flyway overlaps with the North American flyway in Alaska, creating the possibility that North American migratory birds will eventually become infected.

Modes of Transmission and Infection Control

- ▶ High-risk activities include butchering, defeathering, and otherwise handling diseased birds, suggesting that close contact is required. Unusual practices, such as using the mouth to suck bloody secretions out of a fighting cock's beak have also been reported to induce illness.
- ▶ Children playing in areas contaminated by infected poultry waste have become ill, and the virus may remain viable in feces for up to 30 days in low temperature conditions, suggesting that infection may be transmitted by fomites and hand to mucous membrane contact.
- ▶ There is an anecdotal report of two cases that may have resulted from drinking raw duck's blood. All influenza viruses are killed at normal cooking temperatures; there have been no epidemiologic links between the disease and consumption of well-cooked poultry products.
- ▶ At this time, human-to-human transmission appears to be an exceedingly rare event: Almost all cases have had contact with diseased birds. In one exceptional case in Thailand, a mother provided physical care to her ill child for several days then became sick without other risk factors for infection.
- ▶ In the event of the development of human-to-human transmission, it is likely that droplet transmission would predominate as it does for seasonal influenza. Close contact within three feet of the patient or the transfer of virus with the hands to mucous membranes poses a risk.
- ▶ Because there is sparse evidence for airborne transmission of seasonal influenza within

crowded populations in enclosed spaces such as airplanes, the possibility of this route of transmission for avian influenza (H5N1) cannot be excluded at this time.

- ▶ At minimum, droplet precautions should be enforced when caring for a patient with suspect or confirmed H5N1 disease. This includes the use of a surgical mask when in the room with the patient, eye protection when there is risk of splatter of secretions on to mucous membranes, and gown and gloves for any physical contact.
- ▶ An N95 mask has been recommended for aerosolizing procedures, such as intubation, nebulizer treatments, bronchoscopy, and suctioning. More conservative recommendations would be to use an N95 mask for the routine care of a suspect or confirmed case of H5N1 disease.
- ▶ Viable H5N1 virus has been recovered from the blood and stools of humans with the disease; therefore, bloodborne and enteric precautions should also be in effect.

Incubation Period

- ▶ Between 48 hours to a week. Preliminary data suggest that the incubation period for H5N1 may be longer than the typical two days of seasonal influenza, but estimation is uncertain because in most cases exposure to poultry was ongoing.

Period of Communicability

- ▶ Because human-to-human transmission of avian influenza (H5N1) has not yet begun, this is unknown.
- ▶ If H5N1 disease follows the pattern of seasonal influenza, adult patients may be contagious a day or two before symptom onset; peak viral shedding occurs within two to three days of symptom onset and parallels the fever curve. In adults, viral shedding ends three to five days from clinical onset.
- ▶ Children may shed seasonal influenza virus up to five days prior to symptom onset, have higher viral titers and shed virus longer than adults: in one study, 5 percent of children continued to shed virus two weeks after the onset of their illness.
- ▶ Immunocompromised persons also shed virus for a prolonged period.

Patterns of Susceptibility

- ▶ Because influenza pandemics are caused by novel influenza strains, to which all humans are immunologically naïve, attack rates are generally 25 percent or more in all age groups.

CONTINUED ON PAGE 10

- ▶ In contrast to seasonal influenza, where the highest morbidity and mortality occur in the very young and the very old, pandemic influenza causes increased deaths in young adults. This was especially pronounced in the 1918 pandemic, where nearly one half of influenza-related deaths occurred in persons 20 to 40 years old.
- ▶ Deaths from H5N1 disease have likewise occurred principally in children and young adults; whether this indicates an innate enhanced susceptibility amongst these age groups or reflects age-related increased risk behaviors (or both) is yet to be determined.
- ▶ Temporal distribution differs between pandemic and seasonal influenza. Whereas seasonal influenza occurs mainly during winter in temperate zones, pandemic influenza may occur at any time of year.
- ▶ Often, pandemic influenza strikes as a series of successive outbreaks, each lasting for a couple of months, then subsiding only to recur several months later. The 1918 pandemic had three waves within approximately one year; the second wave was by far the most severe in terms of morbidity and mortality.

Clinical Spectrum

- ▶ Initially, H5N1 disease closely resembles seasonal influenza, with sudden onset of high fever, headache, myalgias, and cough. Possible early distinguishing features include the following (but the absence of these should not discourage you from considering the diagnosis):
 - ▷ Fewer upper respiratory symptoms
 - ▷ A greater incidence of watery diarrhea in children and adults
- ▶ The clinical course involves rapid progression to lower respiratory tract disease, with most patients reporting shortness of breath in the first week of illness. Tachypnea, respiratory distress, and inspiratory crackles are common, with variable production of sputum that may be bloody.
- ▶ Radiographic abnormalities usually also develop in the first week, with the most common finding being multifocal or patchy infiltrates, sometimes with an interstitial component.
- ▶ When respiratory failure develops the typical ground glass pattern of ARDS on chest X-ray is frequently seen.
- ▶ Respiratory failure may be followed by multiorgan failure, especially targeting the heart and kidneys.
- ▶ Although a single case report of diarrhea with out respiratory symptoms and two case reports of encephalitis without respiratory symptoms have been published, the presentation has been primarily a respiratory illness.
- ▶ The case fatality rate is approximately 50 percent; however, this is calculated solely from patients who had sufficiently severe symptoms to seek medical attention; there is some evidence that mild and asymptomatic infection occur. Population-based

seroprevalence studies in areas with human disease are urgently needed to determine the true case fatality rate.

- ▶ In contrast to prior pandemics, most deaths from H5N1 disease have resulted from primary viral pneumonia, not from superinfection with a bacterial pathogen.
- ▶ Death often occurs within two weeks of the onset of illness.

Non-specific Laboratory Findings

- ▶ Common abnormalities include:
 - ▷ Leukopenia, especially lymphopenia
 - ▷ Mild to moderate thrombocytopenia
 - ▷ Mild to moderate elevation of aminotransferases
- ▶ Less frequently, a picture compatible with disseminated intravascular coagulation results.
- ▶ Severe lymphopenia and thrombocytopenia have been indicative of a worse prognosis.

Treatment

- ▶ The neuraminidase inhibitors, oseltamivir and zanamivir, may be effective in ameliorating the disease if instituted within 48 hours of onset of the illness; however, higher doses and longer treatment courses may be required than for seasonal influenza. Oseltamivir has not been particularly impressive so far in human H5N1 disease, but it has often been instituted fairly late in the clinical course.
- ▶ In one fatal H5N1 case in Viet Nam in which oseltamivir was used, the virus mutated from drug-susceptible to drug-resistant within a period of days. Thirteen other drug-resistant cases in Viet Nam have been reported.
- ▶ It is estimated that once the pandemic strain is known, it will take about six months to develop the pandemic vaccine. Other measures, such as traditional epidemiologic disease management techniques and the use of antiviral drugs, can be looked at as a way of "buying time" until the pandemic vaccine is widely available.
- ▶ Given universal immunologic naivete to the H5N1 strain, induction of immunity will probably require two shots given one month apart.

Pandemic Potential

- ▶ Three conditions must be present to initiate an influenza pandemic:
 1. The virus must be a novel one, to which there is a uniform lack of protecting antibodies in humans worldwide
 2. The virus must be highly pathogenic to man
 3. The virus must transmit in a sustained fashion between humans
- ▶ The H5N1 virus has achieved the first two of these properties, and its predilection for high mutation rates creates concern that it will achieve the third characteristic soon. Mammal-to-mammal transmission has recently been observed in tigers, ferrets, and household cats.

- ▶ The development of efficient human-to-human transmission could occur via one of two mechanisms:

1. A series of adaptive mutations. A pandemic induced by this mechanism would likely begin with small clusters of human-to-human transmission that are controllable with traditional epidemiologic surveillance, case management, and contact tracing. Quarantine and isolation would be important means of limiting spread of the disease.
2. Genetic reassortment, the exchange of genetic material between avian and human strains, could lead to sudden shifts in transmissibility and virulence, creating an explosive pandemic and giving us less opportunity to limit spread. Reassortment could occur in "mixing vessel" hosts, such as pigs or man, if an individual acquired simultaneous infections with both viruses.

Additional Measures for Pandemic Preparation

- ▶ Educational reinforcement about hand-washing and using tissues to cover the nose and mouth when coughing or sneezing is as important for avian influenza as it is for seasonal flu.
- ▶ Even though the seasonal flu vaccine will not protect against the pandemic strain, it is a valuable adjunct to protect the population against pandemic influenza for the following reasons:
 - ▷ A low prevalence of seasonal influenza in the community would reduce the likelihood of co-infection with seasonal and pandemic flu strains, which could lead to dangerous reassortment events.
 - ▷ A low prevalence of seasonal influenza in the community would reduce confusion in the epidemiologic investigation of pandemic influenza.
 - ▷ Seasonal influenza causes over 100,000 hospitalizations in the U.S. every year. A low prevalence of seasonal influenza would reduce stress on a healthcare system already overburdened by the pandemic. The vaccination of healthcare workers, historically a group with low vaccine coverage, has been demonstrated to reduce morbidity and mortality from seasonal influenza in high-risk patients.
- ▶ In prior pandemics, death from secondary bacterial pneumonia was a common complication, so the promotion of pneumococcal vaccine in susceptible persons is recommended. ~



Tuberculosis:

STILL A PUBLIC HEALTH THREAT!

By Kathleen Moser, MD, MPH

World TB Day is March 24th. It is a day to observe that tuberculosis remains one of the world's leading infectious killers.

Tuberculosis (TB), acquired immunodeficiency syndrome (AIDS), and malaria are the top three causes of infectious deaths among adults worldwide. The World Health Organization reports that the level of drug-resistant TB is increasing in most parts of the world (1).

Yet, as TB rages in most of the world, the number of cases in the United States is at an all-time low (14,517) — complacency may be setting in just as we are reaching a critical moment in domestic efforts to eliminate TB (2). Lee Reichman, MD, from the National TB Center in New Jersey, made famous the U-shaped curve of concern. As the rates of a disease decline, concern declines, and funds for the disease are allocated elsewhere, allowing the disease to rebound. This happened before in the fight against TB, resulting in a national epidemic in the early '90s in which the number of cases rose 20 percent in seven years (2). Over \$100 million in new annual funding was needed to reverse the TB resurgence (3).

Federal funding for TB programs and TB research has now been level for several years. Federal rescissions actually reduced TB program funding throughout California in 2005, and larger rescissions are expected before the end of 2006. The Division of TB Elimination at the Centers for Disease Control and Prevention (CDC) is currently identifying areas for funding reductions and must choose among research, education, and assistance to local TB programs. All three may be affected.

In the last 15 years, San Diego has been able to improve TB surveillance, create linkages with physicians, build a strong directly observed therapy program, provide housing for homeless TB patients, work with community organizations, and collaborate with Mexican partners. The number of cases in San Diego has decreased 35 percent since 1993 (469 to 305), yet the rate of decline has slowed in recent years (4). The local public health system must continue the successful strategies that it has relied upon, yet should also move more aggressively into prevention, earlier case finding, regional projects with Baja California, and educa-

tion for high-risk groups and providers serving them. Compared to all areas funded by the CDC, San Diego County already receives less than the median in dollars per case and new rounds of cuts may set our region further behind.

Recent research has started to bring innovation in TB diagnosis and treatment. The QuantiFERON® blood test to detect TB infection was recently approved by the U.S. Food and Drug Administration (5). This test represents the first step forward in the diagnosis of TB infection in 50 years. Yet, TB programs across the nation are struggling to operationalize this test due to the funding squeeze. The CDC's TB Clinical Trials Consortium is a multi-national research effort (University of California, San Diego is a consortium member) to identify better treatment regimens for TB, including a 12-dose treatment course for TB infection (12 doses of isoniazid/rifapentene vs. 9 months of isoniazid) and the use of moxifloxacin in the treatment of active disease. In 2005, human trials were started for five new anti-TB drugs that have shown promise in animal models. These drugs appear to have the ability to shorten treatment to under four months and are highly active when given intermittently. Yet, funding reductions are poised to restrict research efforts.

The crisis in domestic funding comes at a moment when the International Stop TB Partnership is urging the tripling of global investment in TB control. The executive membership includes Bill Gates, who urged funding for international programs to implement the Global Plan to Stop TB (2006–2015). The plan's goal is to improve access to TB programs worldwide and continue research on new tools to fight TB disease, including vaccine development. Because over 70 percent of San Diego's TB cases are among persons born outside the United States, improvements in global TB control are essential for our region (4). Yet, long-term global initiatives will be insufficient to control TB at home in the short

**[C]omplacency
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to eliminate TB.**

term.

It is easy to forget that TB is a worldwide killer and that it is among the most successful organisms ever encountered. It is easy to forget that the number of cases in San Diego rose over 200 percent between 1989 and 1993, less than 20 years ago (4). Time and again, the TB bacillus has been successful exploiting the inattention of its human hosts. World TB Day is a moment to pause and consider our choices. ☺

References:

1. World Health Organization. Anti-tuberculosis drug resistance in the world (Third Global Report). Geneva, Switzerland: World Health Organization, 2004 (Accessed March 1, 2006 at www.who.int/tb/publications/who_htm_tb_2004_343/en/index.html).
2. Centers for Disease Control and Prevention. Reported tuberculosis in the United States, 2004. Atlanta, GA: U.S. Department of Health and Human Services, CDC, September 2005.
3. Institute of Medicine. Ending neglect: the elimination of tuberculosis in the United States. Washington, DC: National Academy Press; 2000.
4. County of San Diego Health and Human Services Agency, TB Control Branch.
5. Centers for Disease Control and Prevention. Guidelines for using the QuantiFERON® — TB Gold test for detecting Mycobacterium tuberculosis infection, United States. MMWR 2005; 54(No. RR-15) (Accessed March 1, 2006 at www.cdc.gov/mmwr/pdf/rr/rr5415.pdf).

San Diego County Health Stats: Tuberculosis

- San Diego County reported 305 cases of active TB in 2005. Persons born outside the United States comprised 71% (218 of 305) of the reported cases. The most frequent countries of birth were Mexico (106 cases), the Philippines (55 cases), and Viet Nam (18 cases) (1).
- Of the 305 cases reported in San Diego County, TB drug susceptibility information was obtained on 249 (82%) of them. Resistance to at least one of the four major first-line drugs was found among 21% (53) of these specimens. Multidrug-resistant strains were found in 1% (3) of the cases (1).

March 24, 2006 is World Tuberculosis Day. For more information, go to The Stop TB Partnership website at www.stoptb.org. To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 285-6479. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

References: ■ 1. County of San Diego Tuberculosis Control Program, 2005.

About the Author: Kathleen Moser, MD, MPH, has been the director of the San Diego County Tuberculosis Control Program since 1989 and the Refugee Health Program since 2004. She attended Medical College of Pennsylvania and received internal medicine training at the University of Massachusetts and a Masters in Public Health from the Harvard School of Public Health. Over the past 17 years she has been involved in TB Control activities at local, state, national and international levels.

The Social Model Recovery:

A BEST PRACTICE TREATMENT APPROACH TO ALCOHOL AND DRUG ADDICTION

By Louise Lecklitner, MS ED, and Bill Crane

Alcohol and other drug addictions cut across economic class, gender, race, and nationality. The County of San Diego, Health and Human Services Agency (HHSA), Alcohol and Drug Services (ADS) contracts with organizations to provide an entire array of services to assist individuals with alcohol and other drug problems. This array of services includes prevention, non-medical detoxification, residential and non-residential treatment, recovery services for adults and adolescents (beginning at age twelve), and court-mandated services, such as "driving under the influence" (DUI) or drug court programs. This article will explore the social model approach to alcohol and drug addiction recovery and how it differs from the disease model.

When dealing with alcohol or drug addiction, some individuals change on their own and others decide to seek professional help (a psychological or

medical perspective), while others rely on the support from family, friends, and the community (a sociological perspective). Nationally, in 2001, 3.1 million people entered some kind of treatment for alcohol and/or drug addiction. Of these, 1.6 million received help for their addiction and subsequent recovery at self-help type groups, and 1.2 million received treatment at an outpatient rehabilitation facility. Both choices yielded positive results (1).

A widely accepted description of addiction by treatment professionals is that it is a disease. Adherents to this concept describe the disease as a "bio-psycho-social" illness suffered by the addicted individual. Belief in the disease concept is viewed among many addiction professionals as the only acceptable addiction model. This belief is so strongly held that any challenge to the disease model is interpreted as an attack on the reality of addiction. According to this model, addicted individuals require professional treatment in order to recover. Treatment methods may include psychotherapy, group and individual counseling in residential and non-residential settings, narcotic replacement, and/or approaches using medication.

Adherents of the social model approach see the environment of the individual as the primary influence that causes the condition known as addiction. Individuals receive cues from the environment they

exist in and interpret these cues through their understanding of themselves, others, and the world that influences their behavior. Social model adherents view the process in which one recovers as that of altering the relationship between the individual and his/her surrounding environment.

Social model recovery seeks to change the environment in which the individual lives, rather than the person. It is achieved and sustained by peer interaction and mutual self-help. In contrast, the disease model is based on treatment where the primary method for recovery is the relationship between the professional therapist (the well person) and the client (the sick person). Recovery is a do-it-yourself plan: Here are the tools; here is a safe and supportive environment; now it's up to you to learn to live without alcohol. An individual learns and sustains personal recovery by "living it" and "sharing it" — holding the belief that "if I hear, I will forget; if I see, I will remember; if I do, I will learn; and if I teach, I will believe." A slogan that one can associate with social model recovery is: "I alone must do it, but I can not do it alone."

In the social model approach, the process is known as recovery. The recovering individual becomes engaged in a "recovery" environment, whether residential (including detoxification programs) or non-residential, where the culture con-

About the Authors: Louise Lecklitner, MS ED, and Bill Crane are program managers at Alcohol and Drug Services, Health and Human Services Agency, the County of San Diego. Together they have over 50 years of experience in the alcohol and drug field.

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stantly reinforces an alternative set of values and beliefs. The core beliefs or values generally include mutual respect and help, teamwork, and belonging to a group that supports recovery. Recovery is a lifelong process and requires a positive attitude. Participants come to believe that individuals can accomplish almost anything by working together as a group. In practice, social model recovery presents a clear expectation that each person is responsible to the others by helping to maintain the recovery environment.

Both the disease and social models usually support continued attendance in mutual self-help organizations, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). However, the two philosophies may view the relationship of these organizations to the alcoholic or addict quite differently. Disease model supporters tend to see self-help groups as "aftercare" or recovery maintenance because they view the individual as still sick. Social model proponents see self-help groups as the primary means to engage in recovery and per-

sonal growth by gaining, then reinforcing and sustaining a lifestyle in which abstinence is the means to achieve personal fulfillment. In social model theory, the mutual self-help groups are the platform where healthy recovery is presented to newcomers, and all have an opportunity to positively engage with others.

To summarize: 1) Social model emphasizes the process of learning through "doing," "experiencing," and providing positive role models; 2) Social model philosophy ensures that programs are cost effective and outcome effective because of their ability to build strong and lasting social support systems; 3) The social model approach is a recognized and effective approach to treatment and recovery that countless individuals benefit from.

For patient referral, ADS services can be accessed through the County of San Diego Access and Crisis Line: 1 (800) 479-3339. The Crisis Line is staffed and is available 24/7 and has access to all languages and TTY. Previously, this Crisis Line was used only for mental health issues. **SDP**

Additional Resources:

- Center for Substance Abuse Prevention: www.samhsa.gov/centers/csap/csap.html
- Center for Substance Abuse Treatment: <http://csat.samhsa.gov>
- Harvard Medical School, Division on Addictions: www.divisiononaddictions.org
- Join Together on Line: www.jointogether.org/home

References:

- 1) U.S. Department of Health and Human Services, & Substance Abuse and Mental Health Services Administration. (2002). Results from the 2001 National Household Survey on Drug Abuse, Volume 1, Summary of National Findings.

San Diego County Health Statistics

- People who begin drinking before age 15 are four times more likely than those who begin drinking at age 21 to abuse or develop a dependence on alcohol (1).
- People with one or more first-degree relatives who abuse or are dependent on alcohol are two to seven times more likely to abuse alcohol or develop dependence on alcohol at some point in their lives (2).

To request additional health statistics describing health behaviors, diseases and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 285-6479. To access the latest data and data links, including the 2004 Core Public Health Indicator document and Community Regional Profiles, go to www.sdhealthstatistics.com.

1) National Institute of Health & National Institute on Alcohol Abuse and Alcoholism. (1998). Age of Drinking Onset Predicts Future Alcohol Abuse and Dependence. Retrieved July 11, 2005, from www.niaaa.nih.gov/press/1998/aging.htm.

2) Grant, B.F. (1998). The impact of a family history of alcoholism on the relationship between age at onset of alcohol use and DSM-IV alcohol dependence: Results from the National Longitudinal Alcohol Epidemiological Survey. *Alcohol Health & Research World*, 22 (2), 144-148.

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— SEE CLASSIFIED AD ON PAGE 31 —

② ① ① San Diego

With all the ways people can connect these days — home phones, cell phones, online — now there's a single phone number to help people connect with community resources quickly and easily: 2-1-1. This comprehensive service offers free, around-the-clock access to health, community and disaster services in San Diego County.

When dialing 2-1-1, callers are linked to a highly trained phone specialist who can answer questions about a variety of services and agencies: where to find child care, employment assistance, food and shelter, protective services and legal aid, counseling, parenting classes, substance abuse, and employment or volunteer opportunities, for example. Information is confidential and offered in more than 150 languages with the help of a language service. Callers can also receive assistance accessing

healthcare, non-urgent medical support for seniors and the disabled.

In times of disaster, San Diego's 2-1-1 will be mobilized within the County's emergency operations system as a central communications link, providing information about evacuation routes, shelters, road closures, and the status of the disaster.

San Diego County residents with T-Mobile USA, Cingular, and Sprint Nextel wireless services can now dial 2-1-1 from their cell phones. In the meantime, cell phone users who need to access information but do not have these wireless services can dial (858) 300-1211. Additionally, 2-1-1 dialing may not yet be available from workplaces that have central switchboards. For questions about reprogramming your office phone system to accept 2-1-1 calls, please visit the 2-1-1 website at www.211sandiego.org.

SDP

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① ② ③ ...

① Phone:

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② Print:

2-1-1 San Diego's publications include specialized directories, resource brochures, and the comprehensive guide to health and human services, *Directions*.

③ Online:

2-1-1 San Diego's online database of nearly 3,000 services enables anyone with internet access to find community resources and search by program or location at www.211sandiego.org or www.informsandiego.org.

San Diego HIV/AIDS:

UPDATE AND NAMES REPORTING

By Terry Cunningham

As the nation begins to prepare for National HIV Testing Day on June 27, the healthcare community is reminded that, while treatment options have tremendously improved in the past decade, HIV/AIDS remains a significant public

AIDS or HIV disease in the State of California over the past 25 years of this epidemic.

The healthcare provider is no longer responsible for creating the non-name code for newly diagnosed HIV cases. Instead, these cases will be reported by name. Only complete cases reported to Community Epidemiology by name will be count-

and laboratory directors or their designees are now required to report all patients by name with a test result indicative of HIV to Community Epidemiology. When a laboratory has a test result indicative of HIV infection, they report a limited amount of information to Community Epidemiology and send the results to the provider.

The provider then forwards a completed case report form to Community Epidemiology.

Community Epidemiology staff are available to assist providers in reporting HIV and AIDS cases — please call 619/515.6675.

Regulations require providers to use the California Department of Health Services Adult or Pediatric HIV/AIDS Confidential Case Report form. The forms include name, gender, date of birth, as well as other demographic information, patient history, and treatment information. HIV case reports for San Diego County residents should be sent to the County of San Diego, HHSA, Community Epidemiology Unit, by mail (1700 Pacific Highway, P511C-A, San Diego, CA 92101) or fax (619/515.6765). Community Epidemiology staff are available to provide an orientation for

National HIV Testing Day Is June 27

health threat. The number of AIDS cases in the United States has increased steadily since 2000. At the end of 2004, there were an estimated 415,193 persons living with AIDS. This does not include the number of those living with HIV disease. HIV is not reportable in all areas of the country. Among those areas that do report, there were 229,411 individuals living with HIV disease at the end of 2004. National trends are showing that HIV/AIDS numbers are growing in the age groups: 15–19, 20–24, 50–54, 55–59, 60–64 and 65 years and older (1). In California the numbers for the same reporting period are: 50,229 living with AIDS, and 27,926 living with HIV. Since HIV reporting began in July 2002, in San Diego on a coded, non-names basis, through April of 2006, there are 4,972 individuals with HIV and, currently, 5,956 individuals living with AIDS. Statistics for San Diego County have been closely following the national trends.

As of April 17, 2006, the State of California changed HIV reporting from a non-name coded system to a name-based system (2). AIDS has always been reportable by name; now HIV is reportable by name. This information stays at the local health department level. Patient identifier information is not transmitted to the Centers for Disease Control and Prevention. Patients can be confident in this system since there has never been a breach of confidential information regarding

ed for federal funding of HIV prevention and care and treatment programs. Healthcare providers must report a case when a patient has a test result indicative of HIV infection. This includes: a) confirmed positive HIV antibody test; b) viral load test for a confirmed HIV positive individual (including undetectable viral load results); c) P24 antigen test; or d) viral isolation test. Providers must report a patient by name upon receipt of a test result (the specimen much have been collected on or after April 17, 2006) indicative of HIV infection and again when the individual meets the AIDS case definition. Always report a case even if it is assumed that another provider may have reported the patient. This helps ensure more complete case capture, which is critical for local prevention and treatment funding.

Healthcare providers

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About the Author: Terry Cunningham has been the chief of the HIV, STD, and Hepatitis Branch of Public Health Services for over seven years. He has worked in AIDS in San Diego for the past 24 years.

San Diego County Health Statistics: HIV/AIDS

HIV reporting and to answer your questions. To schedule an onsite orientation, please call 619/515.6675.

It will take a minimum of two years for accurate numbers of those infected with HIV to be counted in the system. Therefore, the public health department needs the help of the community healthcare providers treating individuals at high-risk for HIV/AIDS and those who are already diagnosed with HIV/AIDS to get accurate numbers in order to receive appropriate funding. Only tests performed after April 17, 2006, can be counted under this new regulation. It is important for providers to advise high-risk individuals to obtain an HIV test. This can be done at either a facility recommended by the provider or at a county HIV testing center. Also, it is important for providers who administer primary medical care to those with HIV/AIDS to order a viral load test. Clients will not be counted unless testing positive after April 17, 2006, or having a viral load test done after that date. National HIV Testing Day (June 27) would be a good time for all healthcare providers to remind their patients at high risk to have an HIV test.

County HIV counseling and testing is available at the Health Services Complex at 3851 Rosecrans Street, Central Region Public Health Center, San Diego Lesbian Gay Bisexual and Transgender (LGBT) Community Center Health Services 619/260.6380, and Mobile Testing Unit at various locations throughout San Diego County (please call 619/296.2120 for locations and times).

Another County of San Diego service for which providers should be aware to mention to patients is the Partner Notification Program. San Diego is a part of the collaborative with the State of California Disclosure Assistance and Partner Services (CDAPS). If a patient would like to have counseling on how to tell a partner that she/he has tested positive for HIV, the County can help. Please call 619/296.2120 and ask for a CDAPS referral. **SDP**

References:

1. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2004 Vol. 16. Atlanta: U. S. Dept. of Health and Human Services, Centers for Disease Control and Prevention; 2005; pages 6-8.
2. California State Senate Bill 699, April 17, 2006.

■ In San Diego County, the mode of transmission for AIDS cases differs from the Nation: 47% of cumulative adult and adolescent AIDS cases in the United States are due to male-to-male sexual contact, while 74% of AIDS cases in San Diego are in that category (cumulative through 2004 for the United States; cumulative through 2005 for San Diego) (1).

■ The rate of HIV infection among men testing only at the County of San Diego Anonymous HIV Counseling and Testing Services sites increased from 1.6% in 2000 to 3.0% in 2005 (2).

June 27, 2006, is National HIV Testing Day. For more information about National HIV Testing Day, please visit NAPWA.org.

To request additional health statistics describing health behaviors, diseases and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at 619/285.6479. To access the latest data and data links, including the 2004 Core Public Health Indicator document and Community Regional Profiles, go to SDHealthStatistics.com.

References:

1. Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report, 2004. Vol. 16. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2005: p 12. County of San Diego, Health and Human Services Agency, Community Epidemiology.
2. County of San Diego HIV Counseling and Testing Data. State of California, Department of Health Services, Office of AIDS.

② ① ① San Diego

With all the ways people can connect these days — home phones, cell phones, online — now there's a single phone number to help people connect with community resources quickly and easily: 2-1-1. This comprehensive service offers free, around-the-clock access to health, community and disaster services in San Diego County.

When dialing 2-1-1, callers are linked to a highly trained phone specialist who can answer questions about a variety of services and agencies: where to find child care, employment assistance, food and shelter, protective services and legal aid, counseling, parenting classes, substance abuse, and employment or volunteer opportunities, for example. Information is confidential and offered in more than 150 languages with the help of a language service. Callers can also receive assistance accessing

healthcare, non-urgent medical support for seniors and the disabled.

In times of disaster, San Diego's 2-1-1 will be mobilized within the County's emergency operations system as a central communications link, providing information about evacuation routes, shelters, road closures, and the status of the disaster.

San Diego County residents with T-Mobile USA, Cingular, and Sprint Nextel wireless services can now dial 2-1-1 from their cell phones. In the meantime, cell phone users who need to access information but do not have these wireless services can dial (858) 300-1211. Additionally, 2-1-1 dialing may not yet be available from workplaces that have central switchboards. For questions about reprogramming your office phone system to accept 2-1-1 calls, please visit the 2-1-1 website at www.211sandiego.org. **SDP**

3 Ways to Connect

① ② ③ ...

① Phone:

Dial 2-1-1. Bilingual information and referral specialists provide personalized information about community resources.

② Print:

2-1-1 San Diego's publications include specialized directories, resource brochures, and the comprehensive guide to health and human services, *Directions*.

③ Online:

2-1-1 San Diego's online database of nearly 3,000 services enables anyone with internet access to find community resources and search by program or location at www.211sandiego.org or www.informsandiego.org.

What's Up in San Diego?

COMMUNICABLE DISEASE REPORTING

By Michele Ginsberg, MD, and Members of the Community Epidemiology Branch

Disease reporting is a very valuable tool in the control and prevention of recognized illnesses, as well as newly identified ones. A report from a physician often triggers an epidemiologic investigation to determine if the case is in a sensitive occupation — such as a food handler, a daycare provider or attendee, or a healthcare provider — and if a public health intervention is needed.

The goal of this article is to highlight several key disease categories and to provide the medical community with an understanding of their important role in initiating the epidemiological investigative process and the impact on the public health of the community. A complete list of communicable diseases reported in San Diego County from 1996 to 2005 is available at: www2.sdcounty.ca.gov/hhsa/ServiceDetails.asp?ServiceID=147.

Enteric Infections

From 2003 through 2005, 4,054 cases of enteric infections were reported in San Diego County. The reporting form (available through the EMAN web-site at www.EMANSanDiego.com) provides a space to report this information. Patients are interviewed to determine if others developed illness. Table A is a summary of recently reported cases for the past three complete years.

Salmonella, shigella, listeria, and E. coli 0157 isolates are Pulsed Field Gel

Electrophoresis (PFGE) typed from specimens submitted to the public health laboratory, and results are posted on the Centers for Disease Control and Prevention-sponsored Secure National Web board where PFGE pat-

About the Author: Dr. Ginsberg is trained in internal medicine and infectious diseases and has been with the County for over 30 years. Dr. Ginsberg is chief of the Community Epidemiology Branch in the Public Health Services Division of the Health and Human Services Agency and medical director for the County Public Health Laboratory. She is a voluntary clinical professor of medicine in the UCSD departments of medicine and family and preventive medicine and adjunct faculty at the SDSU Graduate School of Public Health.

Table A: Enteric Disease Reports and Rate Per 100,000 Population, 2003–05, County of San Diego

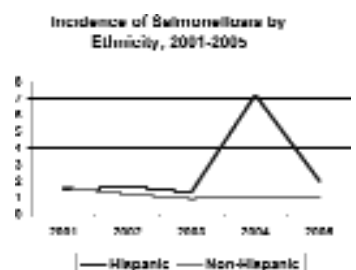
Disease	2003		2004		2005	
	Count	Rate	Count	Rate	Count	Rate
Amebiasis	13	0.4	16	0.5	11	0.4
Campylobacter	580	19.5	534	17.7	485	15.9
Cryptosporidiosis	46	1.5	29	1.0	24	0.8
E. Coli 0157:H7	39	1.3	14	0.5	15	0.5
E. Coli 0157:H7 HUS	1	0.0	0	0.0	0	0.0
Hepatitis A	130	4.4	81	2.7	75	2.5
Salmonella	438	14.7	452	15.0	439	14.4
Shigella	232	7.8	193	6.4	207	6.8
Total	1,479	49.7	1,319	43.7	1,256	41.2

terns can be compared. Two recent investigations revealed the following:

Investigation 1:

A cluster of salmonella cases with an identical PFGE pattern was recognized among patrons acquiring illegal cheese. All cases were Hispanic.

A case control study was conducted, and illness was associated with consuming fresh, unpasteurized Mexican-style cheese, or *queso fresco*. The cheese was purchased from illegal street vendors and from several local markets. This case control study ultimately led to actions by the California Department of Food and Agriculture, the San Diego County District Attorney, and the San Diego County Department of Environmental Health's confiscating the illegal food items, and penalties were brought



against markets participating in the sale of illegal, unpasteurized cheese. Educational materials about the risks associated with raw cheese consumption were developed in English and Spanish and are distributed in multiple sites throughout the county, including WIC clinics. These documents are available at www.sdcdeh.org/deh/fhd/publications.html#food.

Investigation 2:

Salmonella cases were also associated with water dragon lizards. Locally, in San Diego County, an infant was bathed in a tub previously used for a water lizard. A routine public health investigation of this case determined the exposure risk associated with the lizard. Additional testing of the patient and lizard confirmed the link. The unusual salmonella serotype isolated from the child matched other cases in other states that were likewise associated with exposure to these lizards. Once again, public health follow-up and laboratory testing confirmed the successful PFGE matching with other cases.

When a case of salmonella is reported to Public Health, the report, subsequent patient interview, and laboratory evaluation initiate an active search for the source of infection. The ultimate goal is to eliminate the source of additional infections. It all begins with the physician's report.

Central Nervous System (CNS) Diseases

Meningococcal meningitis and meningococcemia occur in all age groups. The local public health jurisdiction requests notification from the medical community when the diagnosis is suspected, prior to laboratory confirmation. Investigation to identify contacts eligible for post-exposure prophylaxis is initiated immediately. Table B lists the recent CNS disease cases reported to Public Health.

Table B: CNS Disease Reports and Rate Per 100,000 Population, 2003–05, County of San Diego

Disease	2003		2004		2005	
	Count	Rate	Count	Rate	Count	Rate
Encephalitis, bacterial	0	0.00	3	0.10	0	0.00
Encephalitis, fungal	1	0.03	1	0.03	0	0.00
Encephalitis, unknown	21	0.71	47	1.56	50	1.64
Encephalitis, viral	10	0.34	5	0.17	6	0.20
Meningitis, bacterial	41	1.38	31	1.03	20	0.66
Meningitis, fungal	8	0.27	4	0.13	14	0.46
Meningitis, unknown	10	0.34	6	0.20	5	0.16
Meningitis, viral	732	24.60	478	15.84	407	13.34
Meningococcal Meningitis	9	0.30	9	0.30	9	0.29
Meningococcemia	9	0.30	10	0.33	5	0.16
Total	841	28.26	591	19.59	516	16.91

A recent case in a college student presented a unique challenge:

A local physician reported a case of meningococcemia in a college student. It was determined that post-exposure prophylaxis should be administered to all close contacts. The family received prophylaxis but was unable to provide the names of the student's close friends. Although the family gave permission for the college to provide the class schedule and provided the case's cell phone, the cell phone was locked. Public health staff worked with the phone company to obtain recent phone numbers called, resulting in over 300 numbers. Interview of these contacts identified a group of close friends with extensive exposure. A total of 18 persons were prophylaxed and no contacts became ill. This example demonstrates how County Public Health Services partners with you, the physician, in identifying contacts who may be at risk, and ensures access to prophylaxis for contacts of an identified case.

Vector-borne Diseases

Outdoor activity is year-round in San Diego. Vector-borne illnesses can be acquired locally. Local vectors can transmit St. Louis encephalitis, western equine encephalitis, West Nile virus, malaria, lyme disease, and plague. In 2004,

a local resident developed the Hanta respiratory syndrome. The individual cleaned rodent-infested enclosed structures at three sites, two of which had been closed for extended periods of time. The individual neglected to take appropriate precautions, such as airing the area for over 30 minutes, dampening surfaces with dilute bleach solution, and wearing rubber gloves. Likely, the patient became exposed to the aerosolized material (i.e., rodent droppings and urine containing the Hanta virus). The initial presentation is non-specific: fever, non-productive cough, malaise, headache, and GI symptoms. Early findings may include a platelet count below 150,000. Rapid progression to pulmonary edema and hypoxia may follow. Obtaining an exposure history is key. Rodent trapping was conducted at the sites where the patient had worked. Hanta virus was identified in field mice trapped at one of the three sites.

Table C: List of the other vector-borne diseases in recent years.

Disease	2003	2004	2005
	Count	Count	Count
Dengue	2	1	7
Ehrlichiosis	2	0	0
Hantavirus Infection	0	1	0
Lyme Disease	2	5	15
Malaria	5	8	12
Q Fever	3	0	0
Relapsing Fever	0	1	0
Rocky Mt. Spotted Fever	0	1	1
Tularemia	0	0	1
Typhus Fever	1	0	0
West Nile Fever	2	2	1
Total	17	19	37

Enroll in EMAN

The Emergency Medical Alert Network (EMAN) provides alerts about potential public health threats and is a resource for disease reporting information, including the confidential morbidity report form. Enrolling is easy at www.EMANSanDiego.com by clicking on "Subscribe to EMAN." Additional information about disease reporting and EMAN is available by calling 619/515.6620. The San Diego County Community Epidemiology Branch thanks you for your prompt disease reporting. It facilitates investigation and overall reduction in disease.

The County Public Health Services Division works with other county offices and state and federal officials to reduce the burden of illness in the community. However, practitioners in the community are the vital link. Prompt reporting of disease and unusual illness allow for efficient investigation and intervention to proceed. SDP

San Diego County Health Statistics: Reportable Diseases and Conditions

- There are over 90 reportable diseases and conditions, including occurrence of unusual diseases and outbreaks of any diseases (1).
- Currently, there are 459 physicians in San Diego County enrolled in the EMAN system (1).

To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at 619/285.6479. To access the latest data and data links, including the Regional Community Profiles document, go to SDHealthStatistics.com.

References:
1. County of San Diego, Health and Human Services Agency, Community Epidemiology.

National Immunization Awareness Month:

AUGUST 2006

By Kathie Gustafson and Harrison Bolter

August is National Immunization Awareness Month and serves as an opportune time to review some of the current issues in the immunization field. Novel and pertinent developments include the threat of pandemic influenza, adolescent immunizations, a new vaccine for the elderly population, and the mumps outbreak in the Midwest.

Avian Influenza / Pandemic Influenza

Two subjects that have been in the forefront of the news this year are pandemic and avian influenza. Efforts at the federal, state, and local levels are focused on how to prepare for these public health threats. The County of San Diego Health and Human Services Agency continues to partner with other county, public, and private agencies to refine its efforts, which include year-round influenza surveillance; information sharing with the local medical community; and developing, testing, and refining a comprehensive response plan. A key component of these plans is public education. County HHSA has created a pandemic influenza information website, with information about avian flu and pandemic flu; local, state, and national response efforts; and links to a variety of other sources of information. The HHSA site is linked to a larger County bird/pandemic flu website, which also includes information from the Department of Environmental Health, the County Veterinarian's Office, and the County Office of Emergency Services (1).

Adolescent Immunization: Human Papillomavirus Vaccine

There are a number of new or recent developments in immunization for adolescents. In June, the Food and Drug Administration (FDA) approved Gardasil® (Merck & Co., Inc.) for use in girls and women ages 9–26. This is the first vaccine developed to prevent cervical cancer, precancerous genital lesions, and genital warts due to human papillomavirus (HPV) types 6, 11, 16, and 18.

The Advisory Committee on Immunization Practices (ACIP) voted in late June to recommend that a newly licensed vaccine, designed to protect against human papillomavirus virus (HPV), be routinely given to girls when they are 11–12 years

old. The ACIP recommendation also allows for vaccination of girls beginning at nine years of age, as well as vaccination of girls and women 13–26 years of age. HPV is the leading cause of cervical cancer in women.

According to ACIP's recommendation, three doses of the new vaccine should be routinely given to girls when they are 11 or 12 years old. The advisory committee, however, noted that the vaccination series can be started as early as nine years old at the discretion of the physician or healthcare provider. The recommendation also includes girls and women 13–26 years old because they will benefit from getting the vaccine. The vaccine should be administered before the onset of sexual activity (i.e., before women are exposed to the viruses), but females who are sexually active should still be vaccinated (2).

The Centers for Disease Control and Prevention (CDC) estimates that about 6.2 million Americans become infected with genital HPV each year and that over half of all sexually active men and women become infected at some time in their lives, making HPV the most common sexually transmitted disease (STD) in the United States. There are an average of 9,710 new cases of cervical cancer and 3,700 deaths attributed to it in the United States each year. Worldwide, cervical cancer is the second most common cancer in women. In addition, HPV is estimated to cause over 470,000 new cases and 233,000 deaths each year.

For most women, the body's immune system will clear the virus and infected women do not develop related health problems. However, some HPV types can cause abnormal cells on the lining of the cervix that years later can turn into cancer. Other HPV types can cause genital warts. The vaccine is effective against HPV types 16 and 18, which cause approximately 70 percent of cervical cancers and against HPV types 6 and 11, which cause approximately 90 percent of genital warts.

Adolescent Immunization: Tetanus Toxoid Vaccines

In spring 2005, two tetanus toxoids, reduced diphtheria toxoid and acellular pertussis vaccine (Tdap) products [Adacel™ (sanofi pasteur) and Boostrix® (GlaxoSmithKline Biologicals)], were licensed in the United States for use in adolescents (and, for one product, Adacel™, use in adults). The pertussis antigen composition of the adolescent and adult Tdap formulations is similar to pediatric DTaP, but some or all of the pertussis antigens are reduced in quantity. The tetanus and diphtheria toxoid composition of Tdap is similar to licensed adult formulations of Td. Early in 2006, ACIP released new recommendations for the use of the Tdap among adolescents aged 11–18 years, including replacing Td with Tdap as the 11- to 12-year-old booster dose (3).

In summary, to reduce pertussis morbidity in adolescents and maintain the standard of care for tetanus and diphtheria protection, ACIP recommends that:

1) Adolescents aged 11–18 years should receive a single dose of Tdap instead of tetanus and diphtheria toxoids vaccine (Td) for booster immunization against tetanus, diphtheria, and pertussis if they have completed the recommended childhood diphtheria and tetanus toxoids and whole cell pertussis vaccine (DTP)/diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) vaccination series (usually five doses of pediatric DTP/DTaP before the seventh birthday) and have not received Td or Tdap. The preferred age for Tdap vaccination is 11–12 years.

2) Adolescents aged 11–18 years who received Td, but not Tdap, are encouraged to receive a single dose of Tdap to provide protection against pertussis if they have completed the recommended childhood DTP/DTaP vaccination series. An interval of at least 5 years between Td and Tdap is encouraged to reduce the risk for local and systemic reactions after Tdap vaccination. However, an interval less than five years between Td and Tdap can be used.

3) Vaccine providers should administer Tdap and tetavalent meningococcal conjugate vaccine (Menactra®, sanofi pasteur, Swiftwater, Pennsylvania) to adolescents aged 11–18 years during the same visit if both vaccines are indicated and available (3).

New Herpes Zoster Vaccine

On May 30, 2006, the FDA licensed Zostavax® (Merck & Co., Inc.) vaccine for use in persons aged 60 years or older. The vaccine is intended to reduce the risk of herpes zoster (shingles). Zostavax® was studied in approximately 38,000 individuals, 60 years of age and older, with half receiving the vaccine and the other half receiving a placebo. After follow-up of participants, for an average of three years, the vaccine was found to reduce the occurrence of shingles by about 50 percent. The vaccine effect was highest for those 60–69 years of age, with a reduction by 64 percent (4).

Herpes zoster is estimated to affect 2 in every 10 people during their lifetime. Annually, it is estimated that one million or more cases of shingles occur in the United States. At press time, ACIP was formulating recommendations for use of this vaccine.

Mumps Outbreak in Midwest

As of June 6, 2006, 4,400 cases of mumps had been reported by 11 states. The outbreak in Iowa and surrounding states and previous evidence on mumps vaccine effectiveness and transmission resulted in ACIP's updating recommendations for mumps vaccination. These recommendations included changes to acceptable presumptive evidence of mumps immunity, routine mumps vaccinations for healthcare workers, and expanded use of mumps vaccine in outbreak settings (5).

About the Authors: Kathie Gustafson recently retired as chief of the County of San Diego Health and Human Services Agency's Immunization Branch. She worked in Immunization for more than 16 years, the last few as branch chief. She is currently president of the California Coalition for Childhood Immunization and serves on the board of the National Coalition of Immunization Coalitions. Harrison Bolter is the health information specialist for the County of San Diego Health and Human Services Agency's Immunization Branch. He has held this position for the past 10 years and is involved in the production of educational materials, in both printed and electronic form, for the branch.

The recommendations are summarized below:

Acceptable Presumptive Evidence of Immunity:

- Documentation of adequate vaccination is now two (2) doses of a live mumps virus vaccine instead of one (1) dose for: school-aged children (i.e., grades K–12); adults at high risk (i.e., persons who work in healthcare facilities, international travelers, and students at post–high school educational institutions).

Routine Vaccination for Healthcare Workers:

- Persons born during or after 1957 without other evidence of immunity: consider two (2) doses of a live mumps virus vaccine.
- Persons born before 1957 without other evidence of immunity: consider recommending one (1) dose of a live mumps virus vaccine.

For Outbreak Settings:

- Children aged 1–4 years and adults at low risk:

if affected by the outbreak, consider a second dose [minimum interval between doses = 28 days] of live mumps virus vaccine.

- Healthcare workers born before 1957 without other evidence of immunity: strongly consider recommending 2 doses of live mumps virus vaccine.

While there have been no confirmed cases of mumps in San Diego County, it is important for healthcare providers, especially those working in college and university student health centers, to be aware of current mumps vaccination recommendations to help prevent a potential outbreak in San Diego.

Much more information about vaccines and vaccine-preventable diseases is available from the San Diego County Immunization Initiative. Please visit the website at www.immunization-sd.org and go to the healthcare providers section, or call 619.692.8661. National Immunization Awareness Month information is available at the Partners for Immunizations website at www.partnersforimmunization.org. **SDP**

References:

- 1) For more information, please visit www.sdbirdflu.org.
- 2) More information about HPV and the HPV vaccine can be found at the following websites: www.cdc.gov/od/oc/media/pressrel/r060629.htm; www.fda.gov/bbs/topics/NEWS/2006/NEW01385.html; www.fda.gov/cber/products/hpvmer060806.htm; www.fda.gov/womens/getthefacts/hpv.html; www.cdc.gov/std/hpv/STDFact-HPV-vaccine.htm.
- 3) The entire text of the recommendations can be found at: www.cdc.gov/mmwr/PDF/rr/rr5503.pdf.
- 4) More information and links to other resources can be found at: www.fda.gov/cber/products/zosmer052506.htm.
- 5) For more information, including the full text of the recommendations and a list of references, please see this Morbidity and Mortality Weekly Report Early Release (Vol. 55, June 1, 2006) on the Web at www.cdc.gov/mmwr/pdf/wk/mm55e601.pdf.

San Diego County Healthcare Statistics

- In 2005, 371 cases of pertussis were reported in San Diego County. This was more than triple the number of cases (116) in the previous year (1).

- According to the CDC, in 2004, U.S. adults 19–64 years of age accounted for 7,008 of 25,827 (27%) reported pertussis cases. The true number of cases among adults 19–64 years of age is likely much higher, estimated at 600,000 annually (2). Providers can and should begin using Tdap vaccine for adult patients when medically indicated.

August is National Immunization Awareness month. For more information, go to PartnersForImmunization.org. To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends, and comparisons to national targets, please call the County's Community Health Statistics Unit at 619.285.6479. To access the latest data and data links, including the 2004 Core Public Health Indicator and Community Profiles document, go to www.sdhealthstatistics.com.

References:

- 1) Immunization Branch, County of San Diego Health and Human Services Agency, 2006.
- 2) ACIP Votes to Recommend Use of Combined Tetanus, Diphtheria and Pertussis (Tdap) Vaccine for Adults: www.cdc.gov/nip/vaccine/tdap/tdap_adult_rec.pdf.

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Fall Prevention Begins at Home:

NATIONAL ACTION PLAN TO EDUCATE PUBLIC OF SENIOR CONCERN

By Pamela B. Smith

During September, National Healthy Aging Month, it is startling to realize that every hour an older adult dies by accident as a result of a fall. With greater community awareness of this problem, many of these accidents could be prevented.

A 75-year-old (or older) female living alone has the greatest probability of having a fall. Add to that

[I]t is startling to realize that every hour an older adult dies by accident as a result of a fall.

the use of a cane or a walker, an acute illness, alcohol use, or having had a previous fall, the odds clearly worsen; toss in poor lighting, vision problems, and a few throw rugs and there is an accident waiting to happen.

During fiscal year 2003-2004, more than 7,000 persons over 75 years of age in San Diego County had falls so serious they required help from paramedics, according to the County Emergency Medical Services statistics. That's about 19 seniors each day. (For additional data on falls, refer to the San Diego County Elderly Falls Report, August 2005, prepared by County Emergency Medical Services and Aging and Independence Services.)

Everyone stumbles once in a while, but when a frail, older adult falls, the results can be life altering — even fatal. For people 75 and older, falls are the leading cause of injury death. Of those seniors who survive their falls, many suffer serious injuries, including hip fractures and head trauma. Once hospitalized for a hip fracture, many never function well enough to live independently again.

Fall prevention is just starting to get the attention it deserves as a public-health issue. The County now has a Fall Prevention Task Force and just completed a video for use in presentations. This coalition also has materials in several languages promoting awareness about devices to help mobility and

safety. It also sponsors Senior Safety Days, which is geared at public education about fall prevention.

Last year, the National Council on Aging, with support from the Archstone Foundation and the Home Safety Council, launched a National Action Plan for fall prevention to educate the public, service providers, and health and social service professionals. The plan focuses on four target areas: physical mobility, medication management, home safety, and environmental safety in the community.

Physical Mobility

Physical mobility refers not only to one's ability to move, but to balance and use one's strength as well. Consider that falls are common just trying to get down to, or up from, a toilet. Strengthening thigh muscles is one way to help reduce the risk of a fall during that important activity. The National Council on Aging plan calls for having more physical mobility programs and services for older adults.

The County of San Diego's Aging & Independence Services (AIS) sponsors Feeling Fit Clubs specifically for seniors who have seen a decline in their functioning. The program is geared to addressing issues of flexibility, balance, strength, and helping participants build on their abilities gradually. The Feeling Fit Clubs are evidence-based programs and are FallProof™ certified. AIS has more than 20 Feeling Fit Club sites around the county, some linked with nutrition centers so that seniors can exercise first and then enjoy a nutritious meal. Community colleges partner with AIS in providing instructors. There are other functional fitness programs at YMCAs, gyms, and other settings in the community. Older adults should consult their physician before beginning an exercise program, but almost any senior can benefit from these classes, even if they have been sedentary for a long period of time.

Medication Management

Medication management is important because taking pills improperly or having negative drug reactions can lead to confusion, dizziness, drowsiness, and other cognitive states that increase instability. Seniors should consult with their doctor and pharmacist about any drug-drug interactions with the medications they are taking and learn how a new medication should be taken. They should also use reminders, such as pillboxes, to make sure they are taking their pills properly.

AIS regularly offers "Meet the Pharmacist" days in different



About the Author: Pamela B. Smith has been the director of Aging and Independence Services for eight years, overseeing more than 30 different programs for older and disabled adults. She previously worked for 25 years with the Social Security Administration.

regions of the county. These events encourage older adults to bring all their medications and meet one-on-one with a pharmacist to determine if they are taking their medications correctly and/or if there are any drug-drug or drug-food interactions.

Home Safety

Home safety focuses on reducing hazardous conditions, such as poor lighting, and adding features that will make getting around easier, such as handrails and grab bars.

Just keeping the home straightened up and reducing items in the home can help. Clutter is one of the biggest problems with seniors, especially if they have lived in the home a long time.

Seniors should sort through items in the home and modify the home to reduce the risk of falls. Besides adding a grab bar in the shower, they could install grab bars, or a commode stand, near all the toilets. Grab bars or partial railings help seniors more safely get out of bed. Stairs should have sturdy raisings on both sides of a stairway.

Family caregivers can get help modifying their home or the home of their parents through the Family Caregiver Support Program coordinated by AIS. Through the program, Interfaith Community Services and Jewish Family Services provide a menu of home safety and modification services, including grab bar installation, light-switch repairs, and more.

Environmental Safety in the Community

Environmental safety refers to hazards outside the home, such as cracked pavement, and making improvements in public buildings, such as

handrails and ramps. The National Council on Aging (NCOA) plan suggests informing the public about the environmental hazards to older adults so they will advocate for improvements.

To read more about the NCOA National Action Plan, see www.NCOA.org. Other websites on

the issue of fall prevention include www.StopFalls.org and www.SafeAging.org, which is coordinated through the Gerontology Department at San Diego State University. For more information about the County's Fall Prevention Task Force, contact Tony Potter at (858) 495-5061. **SDP**

Everyone stumbles
once in a while,
but when a frail,
older adult falls,
the results can be
life altering —
even fatal.

San Diego County Healthcare Statistics

- In 1994, the estimated cost of fall-related injuries was \$20.2 billion nationwide. By 2020, the cost may reach \$32.4 billion (1).
- The majority of all paramedic-responded fall injuries among people 55 and older occurs between 10AM and 4PM (2).

To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends, and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 285-6479. To access the latest data and data links, including the 2004 Core Public Health Indicator document and Community Regional Profiles, please go to www.SDHealthStatistics.com

References:

- 1) "Preventing Injury in America: Public Health in Action," Center for Disease Control's National Center for Injury Prevention and Control, 2001-2002.
- 2) County of San Diego, Emergency Medical Services, Prehospital MICN database, fiscal year 2003-2004.

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Teen Relationship Violence:

A RESEARCH UPDATE FOR DOMESTIC VIOLENCE AWARENESS MONTH

By Annie Lyles, MSW, and Amelia Barile Simon, MPH

During a routine examination with a pregnant teen, a local obstetrician noticed bruising that was clearly not routine. When asked, the patient quickly denied any abuse. Unconvinced, the obstetrician connected the teen to a public health nurse, who also asked about abuse. Again, the abuse was denied. The nurse then connected the young woman to a school specially designed to meet the needs of pregnant and parenting teens. At school, the teachers asked and again the young woman denied any problems. After a few

child — a new path initiated by the thoughtful intervention of a medical professional.

This story is key to understanding and addressing domestic violence (DV) among teens. Teens, like adults, experience relationship abuse at alarming rates. They will often deny the abuse and stay with their partner in the hope that the violence will end. While the domestic violence community has developed diverse models and strategies for adults, targeting teens offers a new and perhaps more effective opportunity for DV prevention and intervention.

DV occurring between two teenagers in a dating relationship is often referred to as teen dating vio-

studies that find girls more likely to hit, slap, or kick their partner and that many youth, starting at a young age, are accepting of abusive behavior. Most studies on dating violence though sample college students in North America and, as a result, have not represented different ethnic populations or lower socioeconomic status groups.

The County of San Diego Health and Human Services Agency, Office of Violence Prevention — in partnership with the San Diego Domestic Violence Council TRV Sub-committee and San Diego State University — has examined teen dating violence locally. San Diego County has a diverse ethnic population, and the collaborative partner-

[R]esearchers have found that one in five female adolescents has experienced physical or sexual dating violence.

weeks, school personnel and the teen's new friends sat down with her. "We know something is going on," they said. "Whenever you are ready for help, please call us. You do not deserve this." Two weeks later, the teen called the school in tears. Her partner had beaten her so badly that a boot print was left on her face. She was ready for help.

While difficult to read, this case has a happy ending. Whisked into a shelter and later to a transitional living program in northern California, the young woman is now starting a new life for herself and her

lence or teen relationship violence (TRV). There is a growing body of research on this topic. PubMed (www.pubmed.com) lists hundreds of recent articles detailing the incidence and implications of teen dating violence. Generally, researchers have found that one in five female adolescents has experienced physical or sexual dating violence. The effects of dating violence are serious as it has been linked to depression, low self esteem, post-traumatic stress disorder, and physical injury, as well as alcohol and drug abuse. What is less understood are research

ships formed in the county provided an opportunity to study TRV in special and at-risk populations (e.g., foster care, probation, and teen parents). Over 1,700 adolescents in a variety of agencies (e.g., after school programs, juvenile facilities, public schools) completed confidential assessments regarding their experiences and beliefs about relationship violence during the spring of 2005.

The study found that dating violence was a

CONTINUED ON PAGE SEVENTEEN



About the Authors: Annie Lyles, MSW, oversees and coordinates youth violence prevention and youth development programs in the county and has been involved in designing, developing, and piloting innovative and scientifically based programs to address TRV. Amelia Barile Simon, MPH, is the coordinator for Domestic Violence Programs for the County of San Diego, Health and Human Services Agency Office of Violence Prevention. Her eight years in the field of public health include a diverse array of experiences in women's health and domestic violence prevention.

prevalent problem among teens in the County. Fifteen to twenty percent of the teens stated that they had "kicked, hit, or punched," "pushed, shoved, or shook," or "thrown something at" their dating partners in the past year. Further, teens reported disturbing attitudes about dating violence. Roughly one in three teens said that it was "sometimes," "often," or "always" okay for boyfriends to resort to dating violence when a girlfriend "flirts with someone else at a party," "threatens to break up with him," or when "she is drunk/drugged or acting crazy." Justification and acceptance of violence as exemplified above were related to a higher reported perpetration of violence. Younger adolescents tolerated violence more than older adolescents. In fact, the youngest group of teens (ages 11–13) was more likely to justify or accept violence than older teens (ages 14–18).

The study also found that both boys and girls were perpetrators of relationship violence. Boys were more likely to have beliefs that accept and justify violence when compared to girls, but girls reported being more physically aggressive than boys. Boys did report perpetrating significantly more sexual abuse than girls.

Specific groups of adolescents emerged as significantly more at-risk than others. Male youths on probation perpetrated more physical, sexual, and verbal-emotional abuse than males not on probation. Over 40 percent of the males on probation said that they had "pushed, shoved, or shaken," or "thrown something" at their dating partners. Over one in three males on probation "threatened their dating partner in an attempt to have sex with her." Foster care youth may also be at higher risk for TRV because they reported higher acceptance of violence and justification for male-perpetrated violence than youth not in foster care. Youth living in neighborhoods that had higher rates of reported domestic violence, child abuse, and juvenile crime had higher rates of teen dating violence as well.

As we learn more about TRV, we are discovering adolescence is a critical time to address relationship violence. Relationship violence and its negative consequences are first experienced during this important developmental stage — TRV can be detrimental to healthy adolescent development.

[For a bibliography of this article, please e-mail Kyle Lewis at KLewis@SDCMS.org.]

San Diego County Health Statistics

- In the United States, women 16 to 24 years old experience the highest per-capita rates of domestic violence.
- In California, relationship violence is the number one cause of intentional injury for women 15 to 44 years old.

October is Domestic Violence Awareness Month. For more information, please contact the National Coalition Against Domestic Violence at www.NCADV.org. To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 285-6479. To access the latest data and data links, including the Community Profiles and the 2004 Core Public Health Indicator document, go to www.SDHealthStatistics.com.

Teen dating violence may also be a pathway to adult relationship violence; it is, therefore, best to confront abusive behaviors early on before the violence becomes an enduring pattern that characterizes adult intimate relationships.

There are local and national resources available with more information for professionals and patients. The Family Violence Prevention Fund (www.endabuse.org) and the Centers for Disease Control and Prevention (www.cdc.gov) offer both professional and teen-friendly information. The County of San Diego, through the Center for Community Solutions, operates a 24-hour DV hotline where trained advocates are prepared to provide services that range from general education and referral to crisis counseling and real-time shelter bed availability. The hotline number is 1 (888) 385-4657, and the website can be found at www.dvlinks.org. Another helpful resource can be found on the KPBS website. KPBS has launched a multifaceted media and outreach campaign on domestic violence with a special emphasis on TRV. Their website is www.kpbs.org/domesticviolence.

Confronting abusive behaviors in teens can be difficult. As in the story above, most teens do not want to leave their partner, even when abuse emerges. The American Bar Association (ABA) recently released a set of recommendations for physicians and healthcare professionals (available at www.abanet.org/unmet/teendating/preventionrecommendations.pdf). The ABA recommends:

- Developing a gender neutral approach to teen dating violence;
- Asking an open ended questions about dating;
- Providing information about healthy relationships in the waiting or exam rooms.

Research has shown a high correlation between TRV, teen pregnancy, and sexually transmitted infections — paying special attention and developing specific protocols with these populations is warranted. Healthcare professionals provide a unique opportunity to address abuse in its earliest stages.

For more information on TRV or a copy of the survey report, contact Annie Lyles at annie.lyles@sdcounty.ca.gov or at (858) 581-5804. **SDP**

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- Lilly Fellowship Award (1997) Society of
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- Glenn Foundation Endocrinology and
Aging Award (1998) Endocrine Society.
- President's Award (2005) San Diego
Psychiatric Society.

The Dual Epidemics: DIABETES AND OBESITY ON THE RISE

By Amethyst C. Cureg, MD, MPH

November is National Diabetes Awareness Month. Obesity and type 2 diabetes mellitus, two major causes of morbidity and mortality, are growing public health threats in our communities today. Perhaps even more alarming, obesity and type 2 diabetes are becoming public health threats for our children as well.

The prevalence of diagnosed diabetes mellitus is on the rise and disproportionately affects minority populations. Diabetes generated a staggering cost of \$132 billion for direct medical care and indirect costs due to disability, work loss, and premature death in 2002. It is estimated that 20.6 million people (9.6 percent of the population) in the United States have diabetes. Closer to home, nearly 1.7 million California adults (6.6 percent) age 18 and over have been diagnosed with diabetes, up from 1.5 million (6.2 percent) in 2001. Six percent of San Diegans ages 18 and over have been diagnosed with diabetes.

The number of Americans with diabetes more than doubled from 1980 to 2004. Type 2 diabetes mellitus, the most common form of diabetes, is

In 2005, over half (57.9 percent) of the state's adults were overweight or obese. In addition to type 2 diabetes, obesity has adverse health outcomes such as premature mortality, cardiovascular disease, osteoarthritis, and certain other medical conditions for all age groups. As a pediatrician, it is particularly distressing that obesity has become rampant in the adolescent population, especially among minority groups, with its potential impact on the lives of children. The percentage of young people who are overweight has more than tripled in the past 20 years. In 2004, more than one in four children (27.4 percent) in fifth grade were overweight in San Diego County. Among ninth graders, 23.4 percent were overweight. Overweight children become overweight adults. Some declare that if the current trajectory continues, obesity will overtake smoking as the primary preventable cause of death. Based on current trends, it may become fairly routine for emergency physicians to see angina and myocardial infarction in the 20-year-olds, who, by then, will have had their type 2 diabetes for a decade.

The problem is daunting — there is no quick fix. The war on obesity needs to be fought on many

It is estimated that 20.6 million people
(9.6 percent of the population)
in the United States have diabetes.

becoming increasingly prevalent. Although it still occurs most commonly in adults aged 40 years or older, the disease is increasing in adolescents and young adults — and younger people may especially be at risk for diabetes complications when they acquire the disease at an earlier age. Healthcare providers are seeing more and more younger children with type 2 diabetes. The primary defect of this illness are insulin resistance and insulin deficiency. To date, no single biochemical defect has been found. But there is general agreement that type 2 diabetes is closely linked to obesity — about 54.8 percent of persons with type 2 diabetes are obese, and obesity itself can cause insulin resistance. Alarming is the increasing prevalence of type 2 diabetes that is attributable to a younger population and the increasing rates coincident with the increased rates of obesity.

About the Author: Dr. Cureg is the County of San Diego Health and Human Services Agency maternal and child health director and director of the Child Health and Disability Prevention Program. She is a past vice president of the American Academy of Pediatrics (AAP), Chapter 3, District 9, and serves on the AAP advisory board.

fronts. This year, the County of San Diego Health and Human Services Agency released San Diego's "Call to Action: San Diego County Childhood Obesity Action Plan." Guided by a steering committee of experts in the field, the "Plan" calls for every person in our community to take part in the fight against obesity through strategies in seven domain areas: county and city government, healthcare system and providers, schools, community-based organizations and youth organizations, media outlets and the marketing industry, and business. The foundation of the "Plan" is based on an ecological model that addresses multiple levels of behavioral influence and offers a comprehensive approach to preventing childhood obesity.

As physicians, we are key contributors to solving the childhood obesity problem, but obesity has not received the attention it deserves from clinicians. It is under-recognized and under-treated by pediatric healthcare providers. Few physicians routinely evaluate patients by calculating body mass index (BMI), and few promote breast feeding and healthy weight and lifestyle. Among the reasons cited are: uncertainty of their role in effectively managing and having an impact on the long-term management of obesity, time constraints, lack of reimbursement,

inadequate availability of community resources, and disagreement about effective management.

Increasing awareness, education, and timely identification and management of obesity by pediatric healthcare providers are critical elements in addressing the problem. Effective strategies include: a) promoting breast feeding; b) evaluating all children by calculating BMI and using the Centers for Control and Prevention BMI for age percentile charts; c) educating patients about the serious health risks of obesity because one-third of mothers misclassify their overweight children as being lower than their measured weight status; d) involving the family by encouraging them to make incremental changes leading to a healthier diet and increased regular physical activity; and e) developing skills in motivational interviewing to assist children and their families to be physically active and adopt less sedentary lifestyles and healthier diets. We have the power to influence, therefore, we must advocate at the local, state, and federal level to raise awareness and support local efforts that promote healthy nutrition and physical activity. As health-

care professionals, we have to be more committed to making creative practice changes and become more vigorous in our efforts to counteract the increase in obesity and type 2 diabetes.

The Maternal and Child Health Bureau, Health Resources, and Services Administration Department of Health and Human Services convened a group of experts to craft management recommendations for primary care providers to guide the evaluation and treatment of overweight children and adolescents, available at: www.pediatrics.org/cgi/reprint/102/3/e29.21. For information or to participate in local efforts, the following resources are recommended: American Academy of Pediatrics (AAP) Chapter 3, contact Meredith Kennedy at mkennedy@aapca3.org; San Diego Childhood Obesity Initiative, contact Cheryl Moder at Cheryl@modercommunications.com; and for the Coalition on Children and Weight San Diego collaborative, contact tracy.delaney@sdcounty.ca.gov. **SDP**

[FOR A BIBLIOGRAPHY, E-MAIL KLEWIS@SDCMS.ORG.]

San Diego County Healthcare Stats

Overweight Prevalence Among Children and Adolescents (United States, Selected Years)

- In 2004, of the fifth, seventh, and ninth graders measured, 31.8 percent of boys and 19.4 percent of girls were overweight.
- In 2003, 80 percent of seventh graders reported they exercised vigorously in three of the past seven days for at least 20 minutes — with vigorous exercise being defined as exercise that makes one sweat or breathe hard. Only 65 percent of eleventh graders reported the same.

Source: California Safe and Healthy Kids Program Office, Duerr Evaluation Resources, WestEd. California Healthy Kids Survey (CHKS), Technical Report, San Diego County. Spring 2003.



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Handwashing: PART OF FLU PREVENTION EFFORTS

By Harrison Bolter

Influenza (flu) season is underway in many parts of the country. The federal Centers for Disease Control and Prevention (CDC) estimates that every year 5 to 20 percent of the U.S. population gets this very contagious and potentially life-threatening illness. CDC also estimates that as many as 200,000 persons will be hospitalized because of flu-related complications, and up to 36,000 people will die from flu.

The best way to help protect against flu is to get a flu vaccine each year. The groups for which vaccination with inactivated influenza vaccine (TIV) is recommended are listed below:

- Children aged 6 to 59 months (Note that preservative-free [no thimerosal] is required by California law for those 6 to 35 months of age and for pregnant women. However, the Secretary of the California Health and Human Services Agency granted a temporary exemption from November 2, 2006, to December 14, 2006, to this restriction for influenza vaccine used in children 6 to 35 months of age that contains thimerosal in excess of the legal limit. During this period, children in California 6 to 35 months of age may receive influenza vaccine that is licensed in the United States regardless of thimerosal level, though thimerosal-free product should be used whenever possible. The exemption was requested by the California District of the American Academy of Pediatrics, California Medical Association, California Academy of Family Physicians, and Kaiser Permanente to protect young children against influenza. The exception was granted because of the dangers posed by influenza to young children, and because of a temporarily insufficient supply of the thimerosal-free influenza vaccine formulation licensed for use in young children. The exemption does not apply to pregnant women.)
- Persons aged > 50 years;
- Women who will be pregnant during the influenza season (see note in first bullet);
- Children and adolescents (aged 6 months to 18 years) who are receiving long-term aspirin therapy and, therefore, might be at risk for experiencing Reye's Syndrome after influenza infection;
- Adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma (hypertension is not considered a high-risk condition);
- Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic

metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunodeficiency (including immunodeficiency caused by medications or by human immunodeficiency virus);

- Adults and children who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions, or that can increase the risk for aspiration; and
- Residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions.

Vaccination with influenza vaccine (TIV or Live, Attenuated Influenza Vaccine — nasal spray [LAIV] if indicated) is also recommended for the following persons:

- Persons living with or caring for persons at high risk for influenza-related complications;
- Household contacts and caregivers of children aged 0 to 59 months; and
- Healthcare workers (HCWs):
 - Physicians, nurses, and other workers in both hospital and outpatient-care settings,
 - Medical emergency-response workers (e.g., paramedics and emergency medical technicians),
 - Employees of nursing home and chronic care facilities who have contact with patients or residents.

Also, healthcare professionals are asked to remind their patients that since the flu season often lasts until March or later, getting immunized against the flu in December or later is not too late.

There is another simple practice to help control the spread of flu and other contagious diseases, not just during flu season, but all year long. That practice is proper and frequent handwashing (hand hygiene).

December 3–9 is National Handwashing Awareness Week (an observance to encourage handwashing in promoting health and preventing disease), and a good time to emphasize the importance of handwashing as a tool in flu prevention campaigns. Thorough handwashing, done regularly with plenty of soap and warm water, can help reduce the spread of contagious diseases like influenza, as well as colds, hepatitis A, meningitis, and infectious diarrhea. Handwashing can also play an important role in maintaining overall good health, especially when combined with other behaviors, such as getting enough sleep; exercising regularly; and eating a healthy, balanced diet.

Unfortunately, observation indicates that handwashing may not be as widely practiced as it should be. In a 2005 survey (sponsored by the American Society for Microbiology and the Soap and Detergent Association), 91 percent of adults said they always wash their hands after using public restrooms; however just 83 percent were observed doing so. The survey reported that Americans who said they "always wash their hands" after using the

About the Author: Harrison Bolter is the health information specialist for the County of San Diego Health and Human Services Agency's Immunization Branch. He has held this position for more than 10 years and is involved in the production of educational materials for the Branch.

bathroom in their home (83 percent) and before handling or eating foods (77 percent) was reported. However, smaller percentages of Americans always wash after petting a dog or cat (42 percent), after coughing or sneezing (32 percent), or after handling money (21 percent).

It is estimated that that some bacteria and viruses can live from up to 20 minutes to two hours or more on surfaces like doorknobs, desks, and cafeteria tables. Therefore, it's logical to conclude that poor handwashing (or a lack of it) plays a factor in the spread of contagious diseases like influenza, colds, and other infections.

Handwashing is most effective at reducing the chances of getting and spreading disease if it is done properly and often — especially after using the restroom, before eating, and anytime the hands get dirty. The following are tips physicians and other health professionals can use to inform their patients about proper and thorough handwashing:

1. Wet hands with warm running water.
2. Apply liquid or clean bar soap.
3. Away from the running water, rub hands together vigorously and make a soapy lather. Scrub all surfaces, the front, the back, under your fingernails, and around the wrists. Take about 15 to 20 seconds (for instance, instruct children to sing the song "Happy Birthday" twice). A fast splashing does not remove germs.
4. The soap together with the scrubbing action dislodges the germs.
5. Rinse well under warm running water to remove the germs and dry hands with a clean towel. Turn off the water with a paper towel.
6. The paper towel should be thrown in a wastebasket when finished.

If soap and running water are not available, hand wash gels containing at least 60 percent alcohol significantly reduce the numbers of germs on skin and are fast acting.

Adults and children should be advised not to sneeze or cough into their bare hands, but to use a tissue (and dispose of it immediately), or their sleeve, whenever possible, and to avoid putting their fingers into their eyes, nose, or mouth.

Health professionals as well as the general public benefit from proper and frequent handwashing. Studies have shown that proper handwashing is the leading measure to prevent cross-transmission of microorganisms and to reduce the incidence of healthcare-associated infections. However, research also has shown that hand hygiene practices in healthcare personnel may be less than desired. A 2004 *Annals of Internal Medicine* article indicated that physicians' adherence to hand hygiene was low in most hospitals. Developing a positive attitude about hand-hygiene by healthcare staff is important to promote these behaviors in patients.

Changing hand hygiene behavior requires time and effort, but it has the potential to pay important dividends in reducing illness through prevention of disease transmission of infections such as the flu. **SDP**

[For a Bibliography, E-mail KLewis@SDCMS.org]


San Diego County Healthcare Stats

San Diego County Immunization Branch conducts an annual random digit dialing (RDD) telephone survey of the residents of San Diego County. One of the surveys conducted this year is that of 1,155 healthcare workers (defined as someone who had direct or face-to-face contact with patients as part of their routine work). The healthcare worker survey primarily pertained to attitudes and behaviors related to influenza immunization (1). Results from this survey included the following:


- 20% of the healthcare workers (HCWs) surveyed reported never receiving a flu vaccine;
- 44% of the HCWs surveyed reported that they worked in a hospital;
- 73% of the HCWs got the vaccine to protect themselves; 10% to protect their patients; 7% to protect their family
- 44% of the HCWs did not agree with the statement, "I think the flu can be severe (headache, fever, chills for up to a week)";
- 33% of the HCWs did not agree with the statement, "I think the flu can make you sick enough to go to a hospital" (1).


To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 285-6479. To access the latest data and data links, including the Community Profiles and 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

1) RDD Telephone Survey, County of San Diego HHSA Immunization Branch, 2006.



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